Co-creating personal and professional knowledge through peer support and peer appraisal in nursing

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CO-CREATING PERSONAL AND PROFESSIONAL KNOWLEDGE THROUGH PEER SUPPORT AND PEER APPRAISAL IN NURSING

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Contents

Peer Support and Peer Appraisal in Nursing

SUMMARY

In this thesis qualitative research methods are used to inquire into whether planned and managed peer support, and peer appraisal, enhance the professional lives of experienced nurses. Research methods were chosen that enabled nurses to explore their own and others' practice, and to share these experiences within a group context. Heron's co-operative Inquiry methodology (1981) was selected to achieve this particular purpose, and other qualitative methods were applied as the research journey progressed.

The fieldwork involved two cycles of research. Twelve participants engaged in the first cycle and met regularly over a period of one year. Eight of these participants engaged in the second cycle meeting regularly over a period of nine months. Rowan's research process (1981) was used to guide the first research cycle. The second cycle developed from the first, with each participant researching their own practice using action inquiry(Torbert 1991). The research group inquired into personal experience, and personal experience methods(Clandinin and Connelly 1995) were used to make sense of this.
During the first research cycle the group sessions were audio taped, and participants used reflective diaries to record personal experiences. During the second cycle reflective diaries, field notes, personal letters and stories provided the field data.

The research process began by exploring the questions: What is there to know about nursing? How do we know what we know about nursing? How do we go about finding out what we know about nursing?

In the first cycle we researched our understanding of 'being' a nurse and nursing. In the second cycle personal practice in the workplace became the focus, and story telling became the vehicle for sharing these experiences. Therefore this thesis is informed by both personal and professional experiences and through these experiences role expectation, life strategies,, power and gender are examined.

Prologue

Introduction

The need for this prologue arose from my viva voce in which a dialogue emerged about the nature of professional knowledge and peer appraisal. I was challenged to provide a clearer guiding frame for the reader who may come to this thesis with, what might be considered, more mainstream ideas about professional knowledge and peer appraisal. This was interesting for me as a researcher because the pattern of this dialogue between myself and the examiners mirrored that between myself and my supervisors, and fellow research students at Bath University, over the course of the research. The tensions within this dialogue were around crispness and clarity of framing about these two concepts for the benefit of an external audience, versus honouring the themes of mutedness and emergence within the field of research itself. Finding a balance across these polarities has been a continuing part of my development as a researcher. In this research I was the initiating researcher; however I sought to develop relationships with the nurses who participated with me, whereby we all developed co-researchers' and co-subjects' roles. While I am mindful of the needs of the reader, I am also vitally concerned to present the research in such a way as to honour the processes which occurred for all of us as we learned to speak from silence and through silence. Therefore I intend to address this dilemma in two ways.

I will provide the reader with a framework for coming to know the research journey that I and my colleagues travelled. I will then respond to the requirements of my examiners to "address the criteria that should be used to judge the quality of the professional knowledge co-created". I intend to present these criteria at the end of this prologue because professional knowledge was co-created within the processes we established to share personal experiences of our lives as nurses. I will begin by mentioning my purposes and framing for the research and then discuss briefly the professional knowledge we sought to define. I will then describe the context we developed to support this process and the way peer support and appraisal provided the structure for exploring our personal experiences of nursing.

Research Purpose and Framing

My purpose on entering this research process was to explore the knowledge that nurses develop through the process of being nurses. In this research I focus on bringing this knowledge to consciousness through affirming the value of individual experience and the confidence to articulate it. As the research progressed, I became increasingly attracted to a constructivist philosophical position and from within this I came to see the knowledge we created in the research as unique to the group. And further, each individual within the group had their own unique meanings about the experiences engaged in. Therefore, the contribution to professional knowledge made by this research is 'process knowledge', namely how we as a group of nurses worked together to inquire into what we understood nursing to be for ourselves, collectively and individually. Therefore this research is concerned as much with

creating a context where nurses are able to speak freely about their experiences of nursing as it is with defining professional knowledge per se.

My energy for researching this aspect of professional knowledge was informed by my experiences of working and studying as a nurse. These experiences provided me with an understanding that professional knowledge is derived and developed in several ways. Nursing theories, models, and practical activities are openly articulated, discussed, researched and debated, and are recognised as a resource for creating professional knowledge. In my experience there is also a sense of knowing about nursing that each nurse develops within the context of caring for and with others. This kind of knowledge is not so clearly articulated and not very easy to research because of the personal and particular nature of the caring relationship. This kind of knowing has more in common with the way oral cultures transfer ways of knowing between one generation and the next. This interactional process of learning to know through immersion within a culture, is the kind of knowing I sought to surface and validate. In order to do this I chose to work with methodologies that resonate with much of the nursing process and the cycles of action and reflection that inform professional practice.

Professional Knowledge

The professional knowledge I engage with in this research, is the knowledge that is developed from the personal experiences of nurses. This kind of knowledge is firmly embedded in each nurse's experiences of caring for and with others, and was recognised by the nurses who participated in this research as being central to nursing. It is knowledge centred in the intuitive, and 'coming to know ', and frequently guides, engages, and underpins action. Re-visioning professional knowledge as being grounded in and emerging from the personal experiences of nurses as they practise nursing, is central to this thesis. The ability to recognise and bring this knowledge into open dialogue requires a degree of self discovery, self esteem and trust in one's own thinking. The challenge for me in choosing to focus on this muted, emerging kind of knowledge, was to create a context that valued personal experiences and self disclosure. Because I believe that nurses are able to locate, explore, and develop this aspect of knowing, I entered this research with the expressed intention of doing just that.

I intentionally moved away from the idea of professional knowledge as being generalisable across time and settings, towards an understanding that it was particular to the individual and the setting in which the experience took place. Consequently, this research is about what nurses themselves value in what they do, and seek to improve, and how they develop a sense of confidence and capability. It is also about finding a voice and a language to articulate and validate these experiences. To the extent that this thesis is a contribution to professional knowledge, it is 'process' knowledge. Thus it is my hope that nurses who read this will value and explore their own knowledge and experience of being a nurse and feel encouraged to voice these experiences.

Therefore, articulating professional experience and honouring what we came to know as the feminine qualities of nursing became important to voice within the group and within other practice settings. For me at that time it was about holding onto an uneasy and unsure beginning process of making the covert overt, and the silence heard. Encouraging myself and others to speak from silence and through silence, so that people hear and understand this beginning process of nurses working together, is to acknowledge and give voice to what it is we call nursing.

A context for sharing professional experience

From the outset I chose the starting point to be the lived experiences of a group of senior and experienced nurses. I took this starting point because I believed there to be a dearth of literature that speaks directly from experience and through the voices of nurses themselves. Also, my experience over thirty years of nursing in a variety of roles has taught me that a particular context was needed to encourage nurses to talk authentically about their practice. This context is one of open-ness, honesty, trust, and caring for and with each other. Therefore I made a conscious decision not to introduce 'academic' concepts about the nature of nursing and nursing knowledge from the literature at the outset. I considered introducing such concepts to be counter productive and likely to 'silence' the intuitive and tacit knowledge about nursing.

In taking this stance, I assumed that in a group of experienced and senior nurses there would be a richness of knowledge waiting to be surfaced about the nature of nursing. I saw my role, as the researcher, to provide processes which would facilitate us in discovering and giving voice to this knowledge. Therefore, as I have already stated, I chose methodologies that resonated with the nursing process and facilitated the development of this kind of professional knowledge. Whilst I was the initiating researcher within these methodologies, I sought to develop relationships among all participants such that we moved towards being both co-researchers and co-subjects. Consequently, apart from methodological contributions as the initiating researcher, any other contributions I made within the group were in the context of 'equal participant'. For example, ideas from the literature about nursing practice, which I introduced to the group as the research progressed, were done so from within my role as 'equal participant' rather than that of 'initiating researcher'. I contributed only as I saw a need to enhance and embellish issues and themes as they emerged within the group.

Peer Support and Appraisal

n this research the terms peer support and peer appraisal are used to refer to the context for exploring our professional experiences and increasing our self awareness of our lives as nurses. I did not intend to construct a procedure of objectives, tasks, and formalised assessment as a way of appraising performance. I considered peer appraisal and support as a continuum with one informing the other. As we worked together issues and challenges were managed with the aim of encouraging self knowledge, self appraisal, and the ability to give and receive constructive feedback. It is important to note that my focus on peer support and

peer appraisal was aimed at developing professional knowledge and exploring the value to each member, of regularly meeting together to share, debate, and find effective solutions to the problems we faced in our lives as nurses. In doing this we explored our roles as nurses and encouraged each other to voice our 'knowing' about nursing.

This sense of 'knowing' developed from our experiences shared within the group, and dispersed into our different work settings. Here we explored, tested and tempered our ways of working as nurses and brought fresh experiences back to the group. The degree to which we were able to develop a context for open and honest dialogue is measured by our ability to share experience, inquire of each other, and to affirm cycles of reflection and action. It was within the process of managing the cycles of reflection and action, that both peer and personal, appraisal were developed. In achieving this we learnt to speak from silence.

Criteria for the co-creation of professional knowledge

The criteria for assessing the quality of professional knowledge, co-created within the context of this research, are to be found within the validity criteria contained within the chosen methodologies. These address the rigour with which the research was carried out, as well as epistemological issues about the quality of knowing of both the participants and myself as researcher.

The literature I used to inform sections of the thesis about 'ways of knowing', life strategies and interpersonal competence, has within it quality criteria that I used to inform and guide the process of developing professional knowledge. The criteria emerged from the interplay between our experiences as nurses and our understanding of the literature. From this standpoint, a constructivist framing is used to make sense of the process of co-creating knowledge through the experiences we shared within the group. In affirming these shared experiences and the meanings they held for us, we also acknowledged that each person was free to incorporate the experience into their lives and develop further understandings in their own way. The research text describes many of these experiences, speaking through dialogue, story, conflict, themes, issues, reflections and ideas. To judge the quality of this co-created professional knowledge, requires both an understanding of the validity criteria contained within the methodologies used, and an ability to journey with the participants as the research unfolds. If one is willing to do this then the following are ways to judge the quality of our 'coming to know ' our lives as experienced nurses.

Experiences within the group

- The nature of the themes that emerged and found resonance across the group as each of us described the 'here and now ' of our experiences.
- The self - disclosure that occurred within the group and the willingness to bring to the group both positive and negative aspects of our lives as nurses.
- The way we actively engaged in cycles of action and reflection to gather and share information about our experiences.

- The way we developed a greater understanding of the nature of nursing through affirming and valuing feminine principles.
- The different ways members of the group engaged in and sought to understand and improve their own practice.

My journey as researcher and participant

- My ability to reflect on my own thoughts, feelings and the possible strengths and weaknesses of my actions.
- The relationships I explore and present as part of my discovery about how I interacted with others and sought to achieve effectiveness within my own work place.
- The sense I made of the themes and issues that emerged and formed a pattern of our shared experiences.
- The passion that I experienced as I created a vision of the many dimensions of nursing - weaving together into a multidimensional schema some feminine principles, a framework for understanding women's epistemology, and the 'essence' of nursing as it emerged for me.
- The links I was able to make between my own experiences of nursing and the writings of other nurses who explore the caring process within nursing.
- The recognition and differing levels of engagement expressed by the nurses who read this thesis and gave me their feedback.

Finally it is important to make clear to the reader that I believe knowledge is co-created through dialogue and within settings for eliciting and affirming it. Consequently the kind of professional knowledge we developed could not have been achieved easily without the group setting for peer appraisal that we created through paying attention to quality of knowing and acting, support and challenge, and a committed engagement over time. It is this process that the reader is about to enter. I have provided just sufficient articulation so that the reader can engage in their own dialogue with this thesis without my voice being dominant. I am inviting the reader to connect with the world of my research, insofar as I can represent it in writing, and to make their own sense of it.

Overview

Some beginning remarks

This research text is arranged in three parts, each part has a particular focus and each one contributes sequentially to the research journey as I chose to write it. However this does not mirror my experience of this journey. I began by searching for an appropriate methodology,, once this was achieved I set up the first field work group and began the research inquiry. The issues and themes that emerged from this field work created a context for personal exploration. These exploratory experiences, together with the experiences I carried with me, into the research informed the beginning chapters in Part One, and all the chapters in Part Three. Thus the final phase of this research journey informed the beginning of the research account. I will now provide an overview of each part as I have chosen to write it.

Part One

I begin by exploring my own life experiences through memories of critical events. These events are taken from my life as a child, adolescent, nurse and woman. The purpose of telling these stories is to affirm the way life experiences make sense of, and locate the person one is. They also give life to the research journey. Having placed my personal self firmly in the research, I then turn to the issues of nursing and being a nurse, and explore these concepts through my own and others' eyes. To achieve this purpose particular nurse writers are selected for their ability to focus on the relationship between the nurse, and the act of nursing. The intimate relationship between nurses, their patients, and their understanding of caring, are the core ideas in this chapter. However I also explore the way nurses support, or don't support, each other in practice, and the use of group work to achieve this.

The third chapter takes a different stance and explores qualitative research methods. The aim of this chapter is to select research methods compatible with the way nurses manage their lives as nurses. To achieve this purpose I explore Naturalistic Inquiry, Co-operative and Collaborative Inquiry, Action Science, the research cycle as a process, and experiential methods. (It is not until later in the field work that I became aware of narrative inquiry and personal experience methods.) At the end of this chapter a summary of the research methods I intended to take into the field work is presented.

In chapter four I describe how I went about bringing together a group of experienced nurses willing to research with me. In doing this I explain the process of recruitment and include some of the comments and questions I received about my research intentions. In outlining how I intended to manage the group , and the research process, I consider suitable research and group management tools, and affirm those applicable to the chosen research methods, and the way I intended to facilitate the group.

Part One

Part Two

Part two contains the first and second research cycles. The first cycle is presented from a group development and research process point of view. This involved identifying stages in group development that were compatible with Rowan's research cycle (Rowan and Reason 1984). To achieve this I drew on my understanding of experiential methods (Pfieffer and Jones 1977). This provided the framework that allowed me to facilitate the research cycle and the group process. Each chapter describes a stage of group development and a phase of the research process: 'Joining' and 'being', 'working and 'project', 'knowledge seeking' and 'encounter', 'sense making and 'communication'. A Co-operative inquiry methodology is used to manage and identify the cycles of action and reflection that we, as co-researchers and co-subjects, endeavoured to pursue. The evaluation criteria within this methodology were used as we reflected on the effectiveness of our work within the group.

The issues and themes that emerged from this cycle of research provided the basis for determining individual research intentions for the second cycle. At the conclusion of the first cycle conflict arose about the use of a Co-operative Inquiry methodology and the research tools of reflection in and for action. This was only partially resolved. During the second cycle of research I revisit this issue of unresolved conflict and present my new understanding in story form in part three.

In the second research cycle each participant chose to focus on particular issues within their own work place. In doing this we all developed our own cycles of reflection and action and shared these within the group context. Reflection in and for action became the focus of our attention as we told stories of our experiences. In exploring my own life as a nurse I began to gain some clarity about my own life strategy and my ways of thinking and acting in the world. The sense I made of this second cycle of research is presented from two perspectives. I begin by using Co-operative Inquiry methods to collect and process the data and then develop story telling as representation of personal experience. This second account is presented in part three.

Part Three

In this part of the research journey I explore gendered life strategies, story telling as a methodology for understanding personal experiences, and I revisit the unresolved conflict in the first cycle. This allows me draw the different threads together and highlight the issues and themes that we as a group discovered through listening to the stories our own experiences.

In chapter ten I explore life strategies, interpersonal competence and the part gender seems to play in the way we interact in the world. In doing this I take time to relate my own life path to Belenky et al 's (1986) explanations of how women learn to 'speak' with their own voice, and value their own minds. This is an important event because their understandings of the way women learn to value their own minds, had a powerful effect on my understanding of myself.

In chapter eleven I explored story telling as a methodology for understanding personal experiences and revisit the data collected during the second research cycle. This facilitated a re-thinking, and re-writing, of the second cycle through the lens of personal experiences and life strategies. Consequently chapter twelve draws together the ideas, issues and themes, generated in chapter eleven and I explore my own personal experiences share at that time. To achieve this I re-visit the conflict in the first cycle and explore the metaphors nurses use to communicate anxiety and stress. This encouraged me to write about the unresolved conflict from a more liberating perspective. I also explored my experience of a particular 'doctor - nurse' relationship from the perspective of life strategies, gendered roles and Women's ways of knowing.

Chapter thirteen is the final chapter and here I bring together the different strands of activity and experience. To do this I review the research journey as if I travelled on three different pathways. Each pathway reflects a different aspect of the research journey and I have named these pathways, 'constraining', 'constructing', and connecting. To complete the picture I present the research journey as one complete research cycle (Rowan 1981). In doing this I am able to take the final sense making and communication phase into the future.

Finally I draw together all the themes and issues we explored as we experienced and inquired into our roles as nurses. This provided the 'living material ' from which a schema of the dialectics of nursing emerged. I then consider how this schema relates to gendered life strategies and ways of knowing. The final product reflects my understanding of the connections between all these aspects of my research journey.

Chapter One

Introduction

This thesis is about what it is I do as a nurse, and in what ways this is influenced by who I am as a person. It is also about the institutions that I work in, the people I work with, and the society in which all my relationships are embedded. My experiences as a nurse are not easy to relate to those who are not nurses. I think this is because the way we, as nurses, see and understand ourselves is not how others seem to view us. This sense of disconnection is often alluded to when nurses talk together, sometimes it is openly acknowledged. My sense making of this is that different groups of people have different ideas about what nurses should know and do. To patients, nurses provide the care and nurturing that because of their illness, or lack of support, they are unable to secure. To society, nurses are an occupational group, of mainly women, providing for the ever changing health needs of the population throughout the life span. To other health workers, nurses are there to manage the workplace in a way that facilitates their professional goals. My aim is to do justice to the way nurses understand nursing, and to expose the conflict, pains and pleasures that arise out of competing demands and expectations. In developing this perspective, it is important to acknowledge my own experiences of nursing and of life because they colour much of what I think and do.

Personal and Professional Experiences.

When I first began to explore my personal and professional experiences I found that they fell into two main groups - those that were a part of my developing life as a child, sister, daughter, wife, mother, friend and grandmother, and those that were a part of my life as a nurse. This idea of separating my life in this way seemed artificial because much of who I am transcends this sense of separateness. Consequently, presenting an authentic and coherent account of the experiences that seem to inform this research journey has been a real challenge. My chosen path to achieve this sense of integrity has been to search out the experiences that seem to be central to my acting and being. Whilst involved in this exercise I have become aware of a pattern in my life that reflects certain premises about how I choose to act in the world, and why I filter my experiences as I interact with others. It is important that I begin by presenting these premises because they influence the way I work and give substance to the decisions I make.

These premises are:

- respecting the part that people play in the pattern of life, and the potential for influencing this pattern beyond that which can be visualised or planned;
- honouring others' ways of experiencing the world and understanding themselves;
- holding the belief that people want to do the best they can and are limited by the experiences they have had and the resources available to them;
- supporting others in their fight to own their contribution to any activity;
- working co-operatively achieves far more in terms of quality and quantity than each can achieve alone, and often goes beyond the original intentions;

- acknowledging that learning about nursing is achieved through acting, reflecting, and sharing with other nurses the possibilities that are generated.

I am not entirely sure where these value statements originated. Like this thesis, I think it is a mixture of who I am as a person and the experiences I have had, both academic and experiential. It is this interweaving of experiences that has proved to be both a rich resource and a focus for conflict and confusion. Making clear the personal and hidden aspects of the way I work as a nurse is central to this thesis. The process of doing this has caused me both anxiety and frustration. To liberate myself from this tendency towards negativity I developed a process of reflection and dialogue. These next paragraphs are extracted from notes I made whilst reflecting upon my repeated attempts to find a pathway to guide my writing.

I have tried various ways of introducing my own experiences in written form and each time my attempts have come to no useful purpose. If I try to unfold my journey in a linear way it does not feel authentic. If I allow my mind to flow, then connections occur across time and place. The result is then real for me but confusing for the reader. If I go back into the past and bring forward the experiences that have made me what I am, then I can write in simple language, providing the situation occurred early in my life. As I progress through my life the pictures and perspectives become more complex and multi-dimensional. Consequently, if I describe experiences that have occurred in the last few years then I find that my experiences from the past are aroused and influence the present. Thus when I pay attention to what is happening as it happens, I am simultaneously aware of many people and many events engaging my senses and influencing my decision making. It seems to me now that my experience of beginning this journey was simple, however as the journey expanded so the complexity increased. If I pay attention to the needs of the reader and reduce the layers of meaning, then the essence of me disappears and what I have made accessible to the reader does not feel authentic. The struggle facing me in writing this text is to provide a sense of this complexity without slipping into chaos and confusion.

As I have experienced this research journey I have come to realise more clearly that the way nurses manage this confusion is to tell stories about experiences. These stories often have embedded messages of joy, sorrow, guilt, anxiety, despair and fear. However, from my experience, it is the act of telling these stories that seems to relieve the tensions and anxieties, thus allowing a sense of mutual understanding to be shared. As I write I am aware that story telling is an essential part of nursing - our ability to 'join' together is often within the metaphor of a story. An essential part of my way through this dilemma of communication with the reader is also through stories. I have come to value the telling of stories because they can provide a sense of the experience that connects with the present, and thereby allows a sense of continuity and personal self to be heard. This idea of story as the vehicle for understanding my journey through this thesis is an apt one as it connects the way in which we, as a group of nurses, worked together during the fieldwork. We used stories to expose and manage conflict,

and to share common experiences about nursing and being a nurse. These stories were both personal and professional, transcending the separation between who we are as nurses and who we are as people.

Sharing Personal Experiences through Stories

In order to open up this idea of separateness and continuity of self(s) I will begin by telling some simple stories about myself that reflect some of the ways in which I have gathered knowledge and developed ways of acting in the world. The purpose of these stories is to create a picture of myself as a nurse, and as a person, before I began this research. My impulse is to let each reader draw their own conclusions about the meaning of each story. The telling of my experiences, then becomes the stimulus for the reader's experience of it, and the interpretation is congruent with the reader's sense of the situation. However, I am aware that this would not achieve the purpose of writing for both colour and clarity, so I will separate the stories and provide a rationale for presenting each story and my own sense making of it. The stories presented in this chapter can be grouped into:

- Stories about my early life before I took up nursing as a career.
- Stories about my experiences as a nurse before beginning this thesis.

Each story is selected because it illuminates a particular theme in my life and because it contains people and experiences that remain with me in the present. I will begin each story with a short introduction about when the story was generated, and what was guiding and/or driving me. I will follow this with the purpose I have in telling this story and how it influenced me at that time as well as at other relevant points in my life. Two of the stories are from my childhood and I have named these 'Stories that give me life'. The following four are from my work as a nurse in new Zealand and I have named these stories 'Finding a pattern to live by'. Three of the stories in New Zealand are about working with the Maori people. Each story provides an experience that 'lives' with me.

The stories that give me life

Mothers and Daughters

There is a particular story that I hear from my mother and her family of origin that sometimes gives me pleasure and sometimes pain because it holds a 'double meaning' for me. This story is one amongst many that are told when my mother's family are recalling the qualities of children and how these qualities re-emerge in the adult life. The meaning of the story can alter according to the context in which it is told, sometimes affirming and sometimes criticising. In some ways it is symbolic of my relationship with my mother who is able to alternate between binding and criticising; I recognise my own vigilance in these situations where I make choices between responding with control or openness. I am aware that this vigilance flows over into other experiences where a message can be read in different ways requiring a careful response. In recalling this story feelings of affirmation and criticism are present, together with the knowledge that this experience of ambiguity is also present when I need to consider the consequences of my own actions.

This particular story is central in a discussion about the qualities I had as a child. It is a link with the past that presents me as a responsible caretaker and energetic organiser, a role I have played in my family. I present it here because it illustrates the role of caring, and taking care, that has been a theme throughout my life. This story has its origins during the second world war when I was three years old at the time and attending a boarding school in Somerset. One of my first clear memories was of a very large play room and a very large jack-in-the-box that waved at me from above my head, I must have been very small. I remember my mother leaving me there and telling me to take care of my brother and to help him tie his shoe laces. My brother is four years older than me and has, since then, told me that he was very homesick the first year we spent at boarding school. I do not recall feeling this degree of separation as for me the days were always sunny and full of things to do.

The setting for this story is my aunt's house during a short holiday over Christmas where I was standing on the bed in my mother's room, with my mother, aunt and brother either in or on the bed. I was giving a solo performance of all the different parts in the school's Christmas show and I had apparently memorised all the parts. I began at the beginning, singing all the songs and reciting all the lines of the Christmas play. I was completely engrossed in this presentation when my brother stood up and started to contribute. I apparently swung my arm back at him, knocking him off the bed without a falter in my performance.

This story is told within my family on various occasions, usually it is amusing and highlights my ability to learn everyone's 'part' but sometimes there is a critical edge about my ability to take control and not be put off by my elder brother. I carry both parts with me: an affirmation for being competent, capable, able to amuse and reduce tension; and a watchfulness about taking control to the degree that it minimises others' contributions and ability to perform. I also hear my mother's voice when I recall this story and although the words were not spoken at the time they are connected. The words that I hear are: "It is more important that the boys have secure careers, careers are not important for girls. You must not, therefore, put yourself forward or show you are more capable."

I am very aware that these experiences are a part of the person I am now, particularly in my ability to pursue a task and not be distracted, and in my need to understand the world from the position of others. There is also with me a wariness about overshadowing others. Consequently achieving my own purposes by facilitating other's goals and needs is a stance I often take. My recollections of boarding school hold a sense of being a part of a group, sharing fears, excitement and pleasures, and in some nebulous way there is a connection between these experiences and my later experiences in institutions during my adult life. The sense I make of this is paradoxical because institutions can provide a context for people to explore and reach their potential as well as the most obvious task of meeting societies needs. Organisations and institutions have been a very important part of my life since a very young age and in the main my experiences have been enabling, communal and personally satisfying.

The next story is about the value I place on interpersonal relationships and in particular those that transcend the mundane. This story Illustrates the way in which people from my past play a significant role in enabling me to seek out the potential for innovation and creativity in the present. Certain people in my past, whom I have held in high regard and who have valued me, have encourage me to follow my intuitive understanding and achieve what I passionately believe in. One such person is at the centre of the next story and helped me during my Grammar School years to develop a sense of my own self worth. Her voice still remains with me when I doubt my own thinking and 'go wobbly', or when I am at the edge of chaos and need to make a choice that may place myself in a vulnerable position.

I attended a Convent Grammar School from the age of ten to seventeen, not as a boarder but as a day pupil. I was the only child of four in my family that did not attend boarding school during high school years. I mention this because there is something here about my mother needing my ability to be responsible and to 'take care' during the years when my father was working long hours, my brothers were at boarding school and my sister was very young. I learnt to be capable at an early age, mainly because my mother was not a very consistent person and hated any kind of routine. It was clear to me, as a young person, that my role at home was to be capable whereas my role at school was to be very different.

The stars that shine brightly

As long as I can remember I have always questioned and sought understanding about issues, people, and events. This questioning was often seen as inappropriate by the nuns who taught me, often the remarks on my report at the end of the year indicated that I was, at times, less than biddable. One of the nuns who taught me elocution and drama seemed to respond to my questioning and energy in a different way, and over a period of time we began to have long discussions after my lessons about life, religion, and what my life path might be . Gradually we developed a strong bond and I learnt to find strength in poetry and drama. It was at this time that I learnt to perform and to develop plays out of stories.

The central point of the story occurred when I was about fourteen years old. My mother and I were about to attend interviews to discuss 'O' level subject and as I was waiting for her to arrive this same nun (Madame Cecile Clare) asked me to bring my mother to see her after the interviews. I willingly complied with this request because I regarded her (Madame Cecile Clare) as a friend and ally. The talk began with an exploration of the kind of opportunities open to me when I left school and continued with a discussion about the need for girls to have careers. As we were leaving this kindly nun said "Janet has a rebellious spirit that will take her far, don't let anyone squash it but encourage her to find an avenue that will use her inquiring mind, and adventurous nature." My mother questioned me about this remark and seemed to find it quite confusing as my role at home was to be very down to earth and consistently reliable. My mother agreed that I was very capable of speaking my mind, particularly with my brothers, however it did not seem to me that she had ever considered this to be a strength.

At a later date, when I was leaving school, this same nun talked with me about my future. I remember her clearly as we sat together on a hot summers day in the rose garden watching the younger children play. Her words are etched on my mind. "Always trust yourself and don't throw away your ideas and dreams, they are more important than all the opinions of others. If others reject you then let them be, take the time to know yourself, you are strong enough to stand alone." When I need to gather my strength to continue on a difficult path, or confront a difficult situation, I hear her voice and see her face. She remains a 'star that shines brightly', giving me comfort and trust in myself, and although she has been physically dead for a very long time, for me she is alive and available when I need her words of encouragement.

These two stories speak to the separate parts of myself, parts that I have learnt to listen to simultaneously so that tasks are completed and at the same time questions and creative ideas are held in readiness for opportunities to emerge. Writing these stories has made me aware that many of my most liberating experiences have been centred around institutional life. I have trained as a nurse and as a teacher, I have spent most of my working life teaching and working as a nurse, or developing and managing health services. I have never spent any time really planning my career, and even when opportunities arise I do not link these opportunities to a career path. It would seem that this stumbling along, being 'driven' by some inner quest and finding some resting place where there is unity with others, is a familiar experience for other women like myself. Much that I have read about women's working lives and woman's ways of travelling in the world seems to echo my own experiences. In chapter two I intend to explore these experiences further, particularly as they relate to myself as a woman and as a nurse.

The next stories demonstrate unplanned experiences emerging from a response to the moment because it feels right to do so. The first story is about a major change in my career that came about without any conscious planning by myself, although I do recognise a propensity to take risks in order to seek out new experiences. The following three stories are about my experiences working with the Maori people. In all these stories the patterns of my life are surfaced.

'Finding a pattern to live by'

In this next story I respond to opportunity without considering in any depth the implications for me as a person or for my career in particular. Thus the story unfolds as I, and others, respond to the challenge and the moment.

Challenges Opportunities and Patterns Emerging

The setting is New Zealand in 1970. At the time I was a single parent with two daughters aged ten and eight. Prior to moving back into nursing I had been teaching children at primary school level for three years. This suited my family situation as my children attended the same school, and I was therefore able to manage the dual role of mother and full time teacher. However, I had a mortgage to repay and things were becoming very difficult, so I decided to work as a nurse during the school holidays while my children were with my mother. At that time I had no intention of returning to nursing as a career. I was employed as a staff nurse and because I enjoyed teaching I set up

discussion groups with the nursing students on the ward. This led very easily into exploring my own nursing experiences and the ways in which I might facilitate their desire to know and practice their skills more effectively. My interest in student learning did not go unnoticed and it was only a few months before I was invited to take up a teaching position in the school of nursing. This faced me with a complete change in the way I envisaged my life progressing, and how I managed my own children's education. Somehow it felt right to take the risk, so I agreed and a new phase of my life began.

This new phase commenced with a steep 'learning curve' as I developed both clinical and experiential learning for students, completed an undergraduate degree, and was promoted to Principal Tutor. During this time of rapid learning I worked closely with several staff of other disciplines. An experience stands out for me during this period of my life because it is about the value of taking risks when one is seeking new ways of understanding and being understood.

Taking risks in search of new understanding

From my point of view, at the time, capable nurses were competent knowers and doers, therefore in developing a new curriculum for psychiatric nursing a strong theme of creating knowledge out of doing seemed very important to me. Therefore in order to create a learning environment that explored clinical issues I introduced structured learning experiences that focused on clinical realities. However co-ordination between experiences in the classroom and in the clinical setting was fraught with problems - the need for 'pairs of hands' took precedence over the appropriate preparation of nurses for working in particular clinical areas. Consequently an inequality between different groups of students with regard to clinical experiences developed. This was something I found difficult to accept as inevitable and it led me to negotiations with the New Zealand Nursing Council to develop a new nursing curriculum. The process of developing this curriculum involved a group of colleagues and advisors and it was to this group I turned when faced with the dilemma of co-ordinating theory and practice.

Our discussions focused on various ways of managing student learning experiences. We found that planning 'generalist' experiences was fairly simple, however when it came to managing the 'specialist' experiences it seemed that some students were going to miss out. This was because the level of skill required and the number of patients treated limited the number of students able to gain experience. We decided to tackle this problem together and a novel answer was provided for us by the consultant who led the 'Neurosis Unit'. The idea was to replace the traditional ways of teaching in the classroom with a clinically based experience, thus merging theory with practice. In essence this was to be achieved through student participation in the clinical situation at the same time as learning the theory. The students would participate as a group, managing their own learning and supporting each other through the learning process. This would encourage peer support, discussion and feedback. This change required that I took responsibility for managing the basic theory while the consultant managed the practical experiences and this proved to be a novel way of working together.

We agreed that I would construct worksheets based on the required texts and Graham (the consultant) would arrange for two weeks of intense clinical experience within the neurosis unit. This plan required that we all, myself and the students, participate fully in the clinical programme. For the students this involved group work, a case study and the experience of being part of a therapeutic community. For me it involved being a member of the clinical team with special responsibilities for working with individual students as the need arose. Both the students and myself were included in the staff groups, where strategies and interventions were debated and staff behaviour was both challenged and affirmed. It was in this area of challenging and affirming that much of the 'live' learning took place and the core of this story is about this learning. Managing this 'live' learning experience as it unfolded was an experience that stretched my mind and my sensitivity - this I was aware of at the beginning and sure of at the end.

We planned, in outline, the path that seemed most useful and in doing this agreed a flexible programme that included a variety of possibilities. This feeling of being on the edge of the unknown was reduced to some degree because time was taken to clarify our roles. Graham was to keep the boundaries firm by managing the direction of our work together and I was to support and encourage student participation. This understanding helped me to place myself in the experience with the intention of staying fully aware of myself and of others, particularly the students, however it did not stop me from feeling uneasy and anxious as I held back from questioning possible outcomes. I remember that my discomfort at the beginning of this exercise was about how much I could debate with Graham in front of students and other staff. In the past we had often discussed and debated ideas and ways of working in the clinical setting but this context was very different. For the first few days I worked carefully alongside the students using inquiry as a vehicle for exploration and explanation. My anxiety ebbed and flowed as I, or one of the students, actively contributed to a dialogue that lead into unpredictable territory. As we progressed through the first week I was able to debate my point of view without dire consequences, and the students began to test their skills within the group setting.

Towards the end of the second week, after the case studies had been presented, Graham asked the students if they had sufficient knowledge about their patient to participate in a role play. There was some hesitation as the students 'caught their breath' followed by a vigorous discussion about what this might mean. Each student was required to enter into the personality of the patient they had been working with, and each patient was asked if they would play the role of either a staff member within the group or an observer. Once roles were settled we began the process of participating in a 'community meeting' exploring relationships and agreed ways of working together. The experience was dramatic and is now etched on my memory. When I find myself tempted to relieve tension in a situation of conflict, or when the focus of group activity is on safe and practical agendas, rather than sensitive and hidden ones, I find myself responding in ways that are rooted in the personal changes that I experienced at this time The knowledge born of this experience has remained with me and is often revisited when there is a need to reach deeper into the interactive process and to self-disclose.

The Challenge of Cultural Difference

The next three stories are all centred on my work with the Maori people in New Zealand. I include them here because they present some of the challenges I accepted, the chaos that was created, and the difficulties I encountered as I tried to move through conflict and confusion. Each story is unique and in each I was faced with a challenge that could not be grounded in any certainty from the past. Each presented me with dilemmas that I had never faced before and each was embedded in a context that was in part alien to me. Consequently these three stories are about the kind of change that challenges existing beliefs and confronts stated values of equality, opportunity and racial harmony. All have a common theme of radical change. For me the change went deeper than I ever imagined as I made a serious commitment to the visions of others because of a deep sense of worth and harmony.

I have chosen to write these particular stories because they face me with:

- what is it I do that places me in the centre of radical change?
- what holds me to my purpose and affirms my intentions as the process emerges?

I am always aware when I am involved in activities that challenge my personal beliefs and values that there will be periods of doubt, conflict and soul searching. I hope that the following stories will amply illustrate this. To provide a backdrop to these stories I will begin with an introduction that includes a short explanation of the Treaty of Waitangi, my position within the organisation where these stories emerged and my personal and professional agendas.

The Treaty of Waitangi was signed in 1840 and has been a source of conflict and struggle between the Maori and Pakeha (those of European extraction) ever since. This short extract is taken from the 'Treaty of Waitangi' (Claudia Orange, 1987) and is an attempt to give you, the reader, a glimpse of the complex issues that surround it.

The Treaty Of Waitangi

Treaties with indigenous peoples were not unusual in the history of the British imperial expansion. Most have been shelved or forgotten, whereas the treaty of Waitangi, signed in 1840 by a Crown representative and over 500 chiefs, remains a central issue in New Zealand. This puzzles New Zealanders and there is as much division over the treaty now as there was in the 1840's. Confusion surrounded the treaty from the first. The treaty in English ceded to Britain the sovereignty of New Zealand and gave the Crown an exclusive right of pre-emption of such lands as the Maori people wished to sell. In return, the Maori were guaranteed full rights of access to their lands, forests, fisheries and other prized possessions. The treaty also promised them the rights and privileges of British subjects, together with assurances of Crown protection. Only thirty-nine chiefs signed this treaty in the English language. However, most signed a treaty in the Maori language which failed to convey the meaning of the English version, most notably that they had signed away sovereignty over their land, and the treaty negotiations did not clarify the difference. In the following years it became clear that the treaty contained the seeds of continuing conflict, particularly over land, power and authority.

In 1984 I was appointed to the position of Director of Nursing for the largest Psychiatric service in New Zealand. Prior to taking up this position I had set up and managed a Community Mental Health Centre for seven years which was part of the same service. I was, therefore, moving within a service and so taking with me relationships, knowledge and agendas. Within three months of taking up my position several of the Maori elders challenged me to begin a dialogue with them about the mental health needs of the Maori people. I say challenge because it is important from the outset that the reader be aware that Maori people traditionally begin a dialogue in ways that are different to the way we in the western culture might 'call a meeting'.

These challenges came in several ways.

- I was challenged in public to do something about the increasing number of Maori people becoming mentally ill.
- A Tohunga (medicine man) would come to see me, with his retinue, requesting to stay with a patient in the hospital so that 'Mate Maori' (illness particular to the Maori people) be treated.
- I was asked to attend a meeting where the crisis for Maori people was to be discussed. This crisis was about the disproportionate number of Maori people held in 'white' institutions, i.e. prisons, psychiatric hospitals and social service care facilities for children.

I responded to these requests/challenges by attending several meetings where I listened to their concerns and responded to their questions. I withheld my own opinion because the main agenda, as I saw it, was about the way in which the institutions disadvantaged Maori people.

Over a period of about three months my relationship with the Maori people moved from being one where I was challenged to account for all the ills that had befallen the Maori people since the Treaty of Waitangi, to one that required a partnership between us. The focus of the discussions moved to a demand for mental health facilities that would be more culturally appropriate for Maori people. I usually attended these meetings alone or with one or two colleagues who desired change, not necessarily people in a position to confront these changes openly. It seemed to me at that time that the concerns and demands of the Maori were seen as marginal by most authority figures. Consequently these meetings were received by those in authority as problems rather than opportunities. However, I had three allies with whom I was able to discuss and review my experiences and it was with this small group that I began to look at the possibilities for working in partnership. Understanding the way the Maori tribal system is organised, and the way decisions are made, is crucial to gaining respect and co-operation. At this point my 'learning curve' was again steep and my ability to create possible scenarios was limited. I relied heavily on being able to discuss situations, thoughts and feelings with people who shared similar intentions. Our agenda was to change the balance of power in an institution that sanitises human suffering and racism.

Creating chaos out of order

This may seem an unlikely title for a change process, however it has been my experience that in visualising a future very different from the present situation the existing order needs to be

confronted. This, more often than not, produces chaos for a time. From my point of view, the ability to create this chaos is a measure of both the appropriateness of the interventions used and the flexibility of the system to confront change.

Talking past each other

The first story is about working with Maori people to develop a mental health service. It challenges my middle class upbringing, my sense of spirituality and the conflict that is present when women choose to stand firm against a patriarchal system. It is also about my own vulnerability as I enter into the meaning making of another culture. It is important for me because I found that entering the world of another culture confronted me with my own roots, and consequently the need to return to England to live. The story began with my intention to work with the Maori people to help meet the needs that they identified as important. I had already developed a small group of like-minded colleagues and we agreed to work towards this partnership in our own work settings. The agreed aim was to involve Maori people in developing culturally appropriate services to meet their mental health needs. The way forward from this point was complicated and immediately made clear to me that I would need to take each problem as it was presented and find a solution that was in harmony with the main purpose.

I encountered the first problem when I agreed to meet with a group of Maori people who came from different tribal areas. The aim of the meeting was to develop a strategy for change and I naively believed that there would be a joint commitment in planning and developing services and that the tribal issues would be managed somewhere else - this was not how it happened. It was unclear who were the 'correct' people to be negotiating with as they were all important, but the degree of importance was difficult to comprehend. It seemed to me that force of personality was equally as important as where an individual was born, and that lineage was very difficult to make sense of because of tribal differences and the decimation of the Maori population.

The services that we intended to provide had to be within the wider Auckland area because that was the way finances were distributed. Several tribes lived within the wider Auckland area and each saw themselves as needing special consideration. They each had a valid rationale for taking power. Each considered that they had a legitimate right to lead and control the negotiating process. The one tribe that had sovereignty over the Auckland area, because of it being their tribal land, were the Ngati Whatua. However, this tribe had been sadly reduced in numbers during the two world wars and were, at this time, trying to regain their tribal land rights from the government who were, in turn, in the process of selling it on the open market. Eventually it was agreed to formalise a meeting time for all the Maori people who wanted to participate, to come together and work towards a solution. This seemed to be the most that could be agreed upon by the Maori people, and the minimum from my point of view if we were to move forward at all.

It is important to remember at this point that the coming of the European to New Zealand halted the natural evolutionary change of the Maori in favour of change that introduced western culture. In some ways this "cultural invasion' left the Maori people at a stage where tribal identity remained

with the land that was their birthright, and the trade and negotiations between tribes was halted as the Maori adjusted to the ways of the manuhiri (visitor).

Developing a Cross Cultural Dialogue

At the first meeting an agreement was reached to meet on three further occasions with the aim of finding a way of working across the tribal divides. This first meeting opened my eyes to the gender divide between Maori men and women. The men were very authoritative and led all the discussions. Oratory is highly valued and gives much status to the speaker and so became the focus of any discussion. Consequently they spent a long time talking about the issues rather than confronting the problems and finding solutions. The women, on the other hand, held discussions together outside the 'formal' meetings. They found solutions to immediate problems and worked across the tribal divides to share resources and ideas. There was, however, an observable difference between the rural and urban Maori. The rural women held the history and language of the Maori people but continued to observe the dominance of the western culture and men. Whereas the urban Maori women, fighting for cultural survival, spoke out more readily and at times their anger about loss and hopelessness broke through the formality. Within the many-faceted communication system I observed two levels of decision making and action taking. The men made decisions about the hierarchy of status and the women made decisions about the needs of the young and the survival of the race.

After three stormy meetings an agreement was reached to have one person take a lead responsibility and work closely with families, tribal networks and patients in the two main hospitals. This meeting was followed with a vigorous dialogue wanting me to create a position for a Maori Co-ordinator. I realised during the discussion that they expected the position to be made available immediately and this was the first bit of irony of which I became aware. As my work with the Maori people progressed I found that what they expected of me bore no resemblance to the way they managed their own affairs. They trained me well to stand and take the power of my own culture and at the same time to walk with them as a companion: a friend to share joys and sorrows with but not their power.

The moment that I stepped into this 'double world' became etched upon my mind. It was when I and two of my senior colleagues were asked to make a public commitment to establishing a Maori Co-ordinator. I knew that this step would precipitate a questioning of the beliefs, values and established practices of the institution and that it would place me in a very difficult position regarding my own staff. I also knew intuitively that this was necessary if there was to be any partnership with the Maori people. However, I experienced a flood of apprehension at a physical level and a dialogue within my head that quickly travelled over the possible situations that I might occur. I remember looking around the room and realising that I could anticipate certain attitudes from my own colleagues, but I could not know what the Maori people had in mind. For a few minutes my resolve 'wobbled' as I realised that if I was to take up their challenge I would be facing conflict with my own staff and in particular with the senior clinical staff. In the few seconds I had to

review the possibilities I realised that my energy and my sense of integrity drove me forwards. So began a process of change that confronted the most basic systems supporting the institution, ranging from pay and conditions, to clinical decision making, and most importantly, 'risk taking'.

Titiwhai Harawira was appointed Maori Co-ordinator by the Maori people and immediately took up the position. It took me four months to get this position ratified by the institutional systems which meant that for four months I had to find innovative ways of paying Titiwhai and finding the resources that she continually expected to be available. The recognition of a paid position formalised the change process, making clear that Maori issues were of importance and that ways to meet the mental health needs of the Maori were to be discussed and tested. The realisation that the changes were going to affect the way people worked came slowly. However, the official recognition encouraged some people to state their position, both for and against, and so alliances were formed and hidden racism became transparent. Working through the issues that stood in the way of establishing the Maori Co-ordinator was a challenging experience for me. I found myself in conflict with my colleagues and sometimes with myself as my loyalties were put to the test. However, for Maori and Pakeha alike, some of the issues I confronted brought about a welcome change and released people from unnecessary restrictions. This is important to acknowledge because it made clear to me that institutional practices are often harmful to the culture that created them as well as to those the rules impose upon.

One of the outcomes of the changes was a challenge brought by the Maori people about the racism inherent within the institution. On their initiative, I was approached by a voluntary organisation who provided institutional racism workshops. Their proposal was that we invest in a series of workshops to promote racial awareness in the workplace. I took their proposal to the senior staff meeting and we debated the benefits or otherwise of taking up the offer. We decided that we, as a senior staff group, should participate in the first workshop, then make a decision as to whether it was 'suitable' for our staff. There was an opinion amongst some of my colleagues that 'Maori radicals' ran these workshops, that these radicals were not 'real' Maori but communists. I knew that the course was run by an Anglican priest and therefore considered that my colleagues, once they met the team, would find it acceptable.

The Challenge to Institutional Racism

The second story is about the tension I experience when my understanding of the world and the people within it is in direct conflict with the way in which institutions remain inflexible to the needs of the people within them. For me, this is not so much about the individual but about how people act in institutions so that the stability is maintained and the 'deviant' is suppressed, ostracised or removed. I include this story here because it holds something very valuable. It is about owning the present and through the present making amends with the past. It is also about my own spirituality and the effect the experience had on my own colleagues that I had not anticipated. Again I stepped into the situation believing that it was important to do so regardless of the consequences.

It was a case of trusting in my own integrity and the integrity of others (the Maori people) and coping with the consequences. It was chaos for a time.

This workshop was about clarifying Maori historical truths and confronting the feelings of the Maori arising from the usurpation of their land. This meant understanding the way in which the land is a spiritual entity and embedded in the mythology of the warrior. It also meant acknowledging the feelings of treachery that have arisen through the white patriarchy's destruction of the Maori rituals, beliefs and tribal life. This destruction of tribal life has eroded the use of the Maori language including story telling and oratory. This is because Maori is an oral culture and requires rituals and communal life to survive.

I attended this workshop with a large group of senior colleagues, some with open minds, some believing that there was not threat to them in confronting racism and some intent on devaluing the experience. I tried to prepare myself for the possible responses of others and also for the unexpected. I was very aware that I needed to hold a balance between saying all I thought and felt while also being aware that others did not have the same sense of 'truth' and would be experiencing the situation very differently. I was aware that some senior people saw a possibility for changing working conditions in favour of management flexibility if they supported the Maori initiatives. There were others who wanted to be seen as 'specialist' in Maori culture and so gain control of the development and be the 'voice' for the Maori. My intense belief was that ownership should remain with the Maori people, that nothing should be allowed to detract from their sense of self and ownership of change. Maintaining my own sense of identity was also important. I was aware at the time that I needed to allow myself to be immersed in the experiences while keeping an internal 'watcher'. I was apprehensive because I knew that my own sensitivities about the issues facing the Maori people were very near the surface and could be ignited very easily. The 'watcher' was needed to keep me safe in a situation where I had little or no control.

The team that were to lead this first workshop were all white. The rationale for this was that we (white people) needed to be confronted by our own people about our own institutional racism. The conflict, if any arose, should be between white people and for white people to resolve. A team of Maori people were present as observers to ensure that we did not collude with each other or fail to realise the issues. This team also monitored and gave feedback as the workshop progressed. My role was to participate with my pakeha colleagues.

From my point of view the workshop was a very moving event, the historical presentations providing a very graphic and personal picture of the rapid decline of the Maori people as the institutions in New Zealand developed and trade became international. It reaffirmed for me the need to bring about changes that empowered the Maori people to take charge of their own destiny - in this I felt a passion. Some of my most senior colleagues did not share this viewpoint, they found the experience very threatening and the old agendas about Maori uprisings and civil war were surfaced. As a consequence, managers and heads of professions became divided on the issue of providing the workshops for the staff accountable to them. The hospital manager refused

to allow his administrative staff to attend subsequent groups and the medical staff were not allowed to attend in working time. Despite this, a large proportion of other clinical staff attended and for many it changed their understanding of the ways in which Maori people were disadvantaged within New Zealand society. This had the effect of opening up the wards to more flexible ways of working both with the Maori Co-ordinator and the Maori healers.

Reaching for a Stable State

Within a year a Maori centre had been set up to support and work with families and tribal healers were able to work with individual patients admitted to hospital for treatment. There was a manageable tension between the traditional way of managing mentally ill people against the way the Maori viewed and managed their mental health problems. Conflict arose around the issue of treating people of Maori race differentlyfrom the pakeha, white racism becoming apparent in the accusations that the Maori people were being given advantages. Titiwhai's answer to this was, "Let them all do it our way!"

One major issue that really confronted institutional practice was the Maori concept that the individual could not be treated in isolation from his or her whanau (extended family). This meant that the 'patient' was accompanied not only by their family but also by key members of the tribe. To acknowledge Maori protocol the whanau must be welcomed and fed before the discussion of the problems takes place. This ritual involved a prolonged greeting ceremony followed by a meal and after this a 'meeting of minds' that could last for several days requiring accommodation for all involved. My role in it all was to try and understand the various points of view and respond positively to requests, concerns and conflicts.

The conflict was manageable from my point of view because I was able to maintain my own sense of integrity as I moved between the needs and concerns of nurses, the Maori, the organisational and political demands. My touchstone was the value I place upon fairness and the obligation to right past wrongs. My strength was the way in which I practised nursing and expected others to practice, plus the relationship I had with colleagues and people in positions of power. I also worked hard to manage the present in a credible and authentic way and to not knowingly create new injustices. Within a year the original meeting place (Whare hui) was extended to include a Kohunga Reo (kindergarten) for the children of the patients and the Maori workers. There was a healthy tension between the needs of the Maori to regain their culture and the needs of supportive staff to be included in the developments. The relationship between the different perspectives became much more open and there was acknowledgement of a real partnership. We arrived at a temporary sense of stability until the next step into chaos. This heralds my final story about institutions that have outlived their usefulness to the point that they are creating something evil in their desperation to survive.

The third story is very clearly about the battle that rages to restore and keep alive cultures that, by all logical reckoning, are doomed to die. The story itself is about institutions at their worst. However, the role of this kind of institution is very much about managing the darker side of a

dominant culture. This final story led into the last phase of my work with the Maori people. The focus is the closure of a medium secure unit for mentally disturbed people who pose a threat to society in some way. This unit had been the focus of fourteen inquires over seven years, each inquiry having been followed by recommendations for change. The last inquiry awakened the wrath of the Maori people and as a consequence held media attention for months.

Before I took up my position as Director of Nursing I met with the Regional Director of Nursing and was informed that one of my tasks was to continue with the changes recommended by the last inquiry into the medium secure facilities. I was told informally that the Regional Health Board had recommended that the hospital close and that new facilities be built for the small number of 'dangerous' patients, with the remainder to be managed within an 'open' hospital setting. At this discussion I voiced my concern about the number of Maori men with mental illnesses who were in secure facilities but who had not committed a crime of violence. I made it clear that I would want to make sure that any changes to the secure facilities took this anomaly into account. My concerns were accepted and in turn I was informed that any changes that would encourage a radical change in the provision of treatment for mental illness would be welcome. This commitment from someone in a position of power (a champion) was very important if the kind of changes I had in mind were to be successful. Although this particular story is told last in the sequence, the build up to it was occurring alongside the development of events in the other stories.

Endings and Beginnings

I have used this title because although the ending was very painful, prolonged and costly, the beginning of something new was equally painful, but also liberating and instrumental in exposing the undercurrent of racism and unacceptable practice. Politically and practically, the medium secure unit provided a place for the courts and the prisons to send mentally ill prisoners. In reality those in medium secure units were a mixture of the following:

- people who could not cope with the isolation of prison;
- and people who were mentally ill and a danger to others.

In both prisons and psychiatric hospitals Maori people are over-represented, especially Maori men. Although, at the time, Maori people were only 15% of the total population they represented 60% of the medium secure unit patients. This situation is also reflected in other 'controlling' institutions.

The history behind the necessity to close this hospital was a series of inquiries into malpractice and accidental deaths, the final death being the fourteenth. This death caused a great furore because it involved a young Maori man aged 25 who had been arrested by the police, accused of breaking into a car to sleep, and while on remand in prison became resistant and refused to eat. The staff of the remand prison became anxious about the possibility of suicide and sent him to a secure prison. In this setting he became unpredictable and impulsive. He was placed in solitary confinement and this precipitated a complete withdrawal into himself and so he was transferred into the medium secure unit. [He had never been formally charged.] Approximately four weeks later he died of a massive heart attack. The inquiry concluded that this fatality occurred through a series of

unprofessional interventions, ranging from excessive medication to neglect after electro-convulsive therapy

Beginning a Process of Change

My work with the medium secure unit began with my appointment as Director of Nursing. As lead nurse I worked with the nurses to change practices and improve conditions, and it was important to work towards these changes regardless of the intended outcome. I took this line of action because I believed that it was important to test out the possibilities for progressive change before seeking closure. Although separated at first from my work with the Maori people, the two themes of secure facilities and the development of Maori initiatives gradually merged. As I became more familiar with the organisational culture of the medium secure unit I was able to encourage a working relationship between the Maori Co-ordinator and some of the more flexible staff. Eventually a few of the staff declared their support of Titiwhai and this allowed her to assess some of the Maori patients. At times she was able to encourage a Maori leader to visit the patients but this did not happen often. As time passed it became clear to me that change from within the institution was not possible. The recommendations from the inquiry were not bringing the desired results. There was a surface compliance but this did not bring about change in any real way for the patients. The staff had too much to lose if the changes were implemented fully, particularly financially. This left me with the responsibility to prepare for closure of the unit.

Preparation for closure involved reducing the number of patients in the unit and gradually stopping all new admissions. To achieve this the patients were reassessed by a panel of outside clinicians and progressively placed in other hospitals or back in prison. Within a year the number of patients had reduced from ninety to eighteen, twelve of these being Maori or Pacific Islanders. It seemed that we were managing the process without any major incidents, there were some trouble spots but nothing that caused any major changes. I am not sure that everyone who supported and worked for this closure had a clear understanding of the implications. I was prepared for some major difficulties but not for what actually happened. As the journey unfolded, my involvement with the Maori people became the resource that ensured that the medium secure unit was closed, and stayed closed. I had no idea that soon I would be working as a 'pair of hands' alongside the Maori workers for nearly nine months to support the very fragile solution that was put in place on the day of the closure.

Staying with the Process

The day set for closure was a Monday. On the Thursday of the previous week six of the medium secure unit staff presented a petition to the High Court with the aim of stopping the closure. It was refused and at that point the Health Board executive felt that the closure was inevitable. I did not share their confidence. Although the staff had been paid a lump sum for loss of benefits and were also given secure jobs, they were losing more than they were gaining in real terms. I knew that complete closure relied on the final patients being placed in the open hospital 500 yards away. The patient transfer was to occur on the morning of the final day. I expected something to happen

at the point of moving the patients but I did not know what. On the Sunday evening I rang the Board Executive to be absolutely clear they were committed to the closure, that they did not intend to backtrack. They were all confident that the closure had been accepted. This, I felt, gave me the authority to take action if trouble of any kind arose.

The next morning I went to the unit with one of my colleagues and Titiwhai, our intention being to help take the patients to their new wards. The staff handed me the keys and a letter from the trade unions saying that all the patients had been 'black listed' - no staff in any hospital were willing to take the remaining 'dangerous patients'. The gauntlet was thrown down and Titiwhai picked it up. The irony of this was that a new unit had been set up for 'better' patients and the only solution opened to us was to engage the Maori people and move these 'dangerous patients' to the new unit, which is exactly what we did. We moved into the newly renovated unit and brought in Maori workers to provide the basic staff. I recruited six nursing staff willing to 'break the strike' and so the Whare paia (House to make good) was established.

I and my husband David worked with the Maori people to develop an environment that nurtured the Maori workers and the patients. I was able to give a part of myself to the Maori people and eventually leave New Zealand to return to England with the knowledge that I could not have done any more. They gave me much more than I could explain in words.

Just recently I attended as the guest speaker the first Springboard workshop for women in my organisation, and after I had told my story one of the young participants asked me,

"What has influenced you most in your life?"

I said, "Without a doubt it is my experiences with the Maori people. They helped me to recognise where I belonged and how spirituality transcends racial differences."

The Personal Experience or Carrying Stories

What I learnt particularly from the experiences was the value of developing relationships in harmony with the values I have about people and life. What was most important for me was that I left in a managed way. I had the opportunity to celebrate and grieve with the people I had learnt to love and respect (and fear for at times). One of the reasons both my husband and I decided to leave was because the partnership between ourselves and the Maori people was limiting their ability to really develop their own way forward. I also learnt that separation is sometimes important to allow growth to take a different direction and for people to recognise their choices.

These three stories can be viewed from many different perspectives, each being helpful to me when I need a reference point for reflection and sense making. However, the place where these memories touch me most is around my sense of being a woman, and my desire to break the bonds and shackles that restrain, coerce and inhibit. Sharing a sense of spirituality and power with other women, who have a passionate concern for the pain and suffering of others, was a significant part of each of the stories. The Maori Co-ordinator was, and still is, a powerful and spiritual woman,

and, although from different cultures, we shared a deep understanding of each other. If I was feeling worn down with the conflicts, confusion and the sheer physical energy required of me, she would notice and open her arms to me. If she was feeling attacked and unable to defend herself, I would take her part and use my resources to affirm and defend her. We both used our power and strength to protect and support each other, not needing to question. Feeling the need in the other was sufficient. When I am driven by my desire to break the bonds and shackles that inhibit creativity in people and organisations I know that it will not be a simple task with a simple solution. It will be a journey into the unknown with my past as a guide and with conflict, confusion and surprise my companions along the way.

Although I have learnt to pay attention to the beginnings and endings of each phase of my life, it is clear to me that the experiences are very personal and powerful and will continue to influence both my thinking and my doing, regardless of how much I take care of the leaving process. In pondering this connection to people in the past, it seems to me that in some extraordinary way they are part of me, intertwined with others present now. I intended to make a clean break with New Zealand, I carefully managed my departure so that I would not carry any 'unfinished business' with me. However, once the sense of freedom had faded and I began to feel the challenge and the energy, this connectedness with the past became alive and part of the present again.

Conclusions

In this chapter I have endeavoured to present key aspects of who I am through stories. I have chosen the medium of story-telling, because it is familiar to me and is a part of my personal and professional life. For me, each story has levels of meaning embedded in it. I hope that the telling of it, and the meaning I took from it, is sufficiently communicated. I am aware that much of the meaning taken from human action is symbolic, and therefore my interpretation of these stories may not 'fit' for others. Each story exposes something of myself, the context that 'held' the experience and the learning I took from it. In each experience I gained a further sense of 'self' and in presenting these experiences I intended that the reader would gain some sense of me as a person. The reason I have chosen to pursue this theme of personal self is because this thesis is about me being a nurse and this requires that I use myself as a tool to work with people

In the next chapter I will explore the meaning of nursing to nurses through the literature that enlightened particular aspects of nursing and informed my own experiences of being a nurse.

Chapter Two

Introduction

Arriving in England after being away for nearly thirty years gave me the space and the time to think about what I had achieved and whether I wanted to continue along the same path. My experiences since returning to England have given me more freedom to focus on nursing and being a nurse, and this research process has brought me to the point where I am able to write about these experiences. In this chapter I will explore these experiences from both my point of view and the views of other nurses, beginning by introducing my perspective of nursing and being a nurse and then focusing on what I term the essence of nursing. In doing this I will reference nursing writers who I value for their ideas, experiences and insights. This will bring into focus nursing as a caring profession and what caring means to nurses and to society. I will then explore the genderedness of the nursing role and team work and peer support within the context of nursing.

I have chosen to include the views of only a few nurses, selected because they speak to the nature of nursing and tell about a developing understanding of the essence of nursing. However there are a wealth of nursing theorists who seek to develop a theory of nursing along either of two dimensions. There are those who seek to base nursing within social, biological, or physical sciences. e.g. Adaptation theory (Rambo, 1984; Roy, 1976); Interpersonal/interactional theory (King, 1971; Peblau, 1988); Systems Theory (Neuman, 1982); and Holistic Health (Rogers, 1970). Or alternatively there are those who seek to develop models and procedures for managing nursing care. e.g. 'Activities of daily living' (Roper, Logan and Tierney, 1988) and 'Self care' (Orem, 1980).

All these nurses, and many more, write about the knowledge and practical guidance nurses need to manage their work and make informed decisions. This is all very important to the development of informed practice and effective evaluation. However my interest is in how nurses use this knowledge and skill in a way that is 'health giving' and in doing so become expert in understanding and responding to the subtle signs of dis-ease. It is this receptiveness and responsiveness, characteristic of expert nurses, that I intend to make the focus of my inquiry.

Nursing and being a nurse

My experiences of nursing and being a nurse cover many years and explores many different contexts. It is this which has given me a wider perspective of what nursing is and what nurses do. However knowing about one's experience, and writing about it, is all very difficult because as I have come to know about nursing so I have come to know about being a women in western society. My understanding of each is intertwined with the other. It has been through puzzling out this relationship that I have discovered the genderedness of my life as a nurse. The reader should not take from this that I believe that nursing is about being a woman. I have discovered too much about my feminine and masculine self to see nursing so simply.

I am aware from the experiences I have shared with other nurses that being both a nurse and a woman incur similar expectations about roles and responsibilities, regardless of the gender of the nurse. In this chapter I intend to focus on nursing and to 'bracket off' the ever present sense of being a woman. I will entertain this concept when I discuss life strategies and gender in Part three. I now intend to explore what I have come to know as the 'essence of nursing'. To illustrate and discuss this concept I will invoke the perspectives of three expert nurses: Benner (1984) for her work on the development of the expert nurse; Binnie (1993) for her ability to demonstrate to the uninitiated the expert role; and Newman (1990) for her self-discovery while pursuing nursing research.

The development of the 'expert' nurse

I will begin this section with the following quote from **Myrtle K. Aydelotte-** extracted from the forward to Benner(1984)

> "The value of this document lies in the understanding it gives us about the mystery of expert nursing practice and in the creation of an awareness that we must respect this mystery, rather than pretend that we can dispel or standardise it by submitting it to rules, procedures and regulations."

Benner (1984) researched the question "How do nurses develop from novice to expert?". The methods used, the process engaged in, and the outcomes achieved all inform what I have come to understand as the essence of nursing. Benner was interested in how the actual experiences of nurses uncover and create knowledge. These kinds of experiences, according to Benner, occur when "an event refines, elaborates, or disconfirms foreknowledge". This is termed clinical knowledge, and is "a hybrid between naive practical knowledge and unrefined theoretical knowledge."(p. 8) A new paradigm is then available to manage future situations. It is the development and use of these paradigms that interested Benner, and formed the basis for research into the experiences of nurses.

The research methods used by Benner involved the application of the Dreyfus (1979) model of skill acquisition. Dreyfus, in working with trainee aircraft pilots, produced five levels of proficiency: novice; advanced beginner; competent; proficient; and expert. These levels of proficiency correlated to five stages of development. In order to become an expert, students needed to master three different aspects of skilled performance. These three aspects of change in performance become the 'benchmarks' for assessing the individuals level of proficiency. To develop from novice to expert the individual must demonstrate that they have moved from:

- reliance on abstract principles to the use of past concrete experiences as paradigms;
- seeing the situation as a set of equally important bits to a complete whole, where only some parts are relevant;
- being an observer in the situation to being thoroughly engaged in the problems to be solved.

These three areas of change provided the focus for discovering the competencies at each stage of development. To test out this model Benner used paired interviews with a beginning nurse and a nurse considered by other nurses to be an expert. A situation experienced by both nurses was identified and each nurse was interviewed, thus producing two narratives for the same situation. An interpretive approach was then used to analyse the data, thus "allowing a manageable yet rich description of actual nursing practice"(p.39). This interpretive approach takes into consideration the context in which the experience occurs and the individual's meaning making. Benner also makes the point that clinical competency level is much easier to ascertain when the assessment is made by nurses who share the same background meanings. That is, the participants can talk about them (*their experiences*) and the interpreter, who shares their knowledge and experience base, can understand them.

From this research Benner was able to identify seven domains of nursing practice and within these domains specific competencies. These seven domains are:

- the helping role;
- the teaching-coaching function;
- the diagnostic and patient -monitoring function;
- the effective management of rapidly changing situations;
- administering and monitoring therapeutic interventions and regimens;
- monitoring and ensuring the quality of health care practice;
- organisational and work-role competencies.

From this analysis the competencies to move from novice to expert within each domain can be identified.

The Narratives of Nurses

Benner found, by listening to the narratives of expert nurses, that the key to their development of expertness was based in their ability to 'experience' nursing, and to integrate this experience into both existing and new knowledge. From this integration of experience and knowledge, new paradigms are developed and available in future 'like' situations. Benner also observed that as the nurse gained more experience, paradigms were grouped together to better inform particular health care problems. However, the problem that arises from this way of becoming an expert is that knowledge gained tends to remain with the expert nurse and is only shared within the work context. Thus inexperienced nurses learn through being with, and listening to, expert nurses. Teaching the skills needed to be an expert nurse is not formalised.

One of Benner's concerns about this work-based knowledge is that nurses do not articulate clearly the knowledge they have developed, either by reporting and recording or by planned discussions with other nurses. Benner also acknowledged that:

> "many paradigm cases are too complex to be transmitted through case examples or simulations, because it is the particular interaction with the individual learner's prior

> knowledge that creates the 'experience' - that is, the particular refinement or turning around of preconceptions and prior understandings."(p. 9)

Although some situations do not lend themselves easily to explanation, I concur with Benner that "...adequate description of practical knowledge is essential to development and extension of nursing theory." (p.11)

From Novice to Expert

In summary, Benner clarifies the difference between a novice and an expert nurse through first identifying exemplars of nursing practice, and then by clarifying the proficiencies needed at different levels of development. The methods used highlighted the need to honour both the context and the understanding the individual makes of any given situation. Evaluation of the competency of an individual nurse must therefore acknowledge both context and meaning making, and this is one of the most important points I take from Benner's work. The ability to acknowledge the needs of the novice nurse and the skills of the expert are very important for the development of nursing in a changing society. To this end the experiences of expert nurses should be made more available to the less experienced. These ideas and challenges are embedded in my own cycles of research within the field work and will become more apparent in Parts Two and Three.

The work that Benner undertook has been used by nurses to develop learning environments within the clinical situation. I now intend to present a piece of work by one of my colleagues who explored nursing as a 'craft'. This work explores the skills and knowledge of the expert and uses narrative as a way of 'opening up' the expert's experiences to less experienced nurses.

The expert role in practice

The central reference that I have used to explore this concept is Titchen (1993). In this work the exploration of the art of patient-centred care is investigated from the perspective of the patient and the nursing staff (Binnie and Titchen, 1992). This exploration echoes my own understanding of working collectively with patients, colleagues and novice nurses. Titchen begins her discussions with this quote from Binnie (1992 in Titchen 1993).

> "For me the essence of patient-centred nursing has become developing a relationship which enables me to address my patient's personal experience of health or illness. Then, within this relationship I offer a special companionship and a range of practical skills which, together, if the patient is willing to accept them, have the power to transform his experience." (p 1.)

Titchen, who is not a nurse but a social scientist, uses the data derived from an action research project (Binnie and Titchen, 1993) to explore the role of the expert nurse and from this posited the idea that nursing is a 'craft' that can be learned.

The action research project undertaken by Binnie and Titchen (1993) aimed to change the methods of nursing from traditional and bureaucratic to patient-centred, based on the concepts of holistic care. This required that nurses worked with patients in partnership, honouring the range of needs that inform the individual about his/her health. Binnie, a recognised nursing expert in patient-centred care, led the nursing team through these changes. The action research data collection involved observations of nurses working with patients and other nurses. It also involved recording the stories that nurses tell about their own experiences and the experiences of their patients. It was the story telling that proved to be a rich source for professional craft knowledge to emerge. Titchen in her own words became -

> "...fascinated with Alison's professional craft knowledge- the part of professional knowledge which is acquired mainly through experience and underpins everyday practice."(p 2)

Titchen decided to rework the data from this action research, to investigate the idea of craft-knowledge as applied to expert nursing knowledge. The stories were revisited and produce new themes and sub-themes. The themes that emerged were -

> ".derived from the phrases that Alison used to capture the essence of her knowledge."(p. 4)

There were two major themes, each with sub-themes attached. The first focused on the clinical practice role (the *Skilled Companion*) and the second on the clinical teacher role (*Facilitator of Learning*). Each involved use of story telling and this way of presenting experience makes very clear the value of stories within the learning environment of both patients and staff, not to mention the person telling the story.

The sub-themes of the first major theme The Skilled Companion are:

- particularity;
- mutuality;
- reciprocity;
- graceful care;
- balance between an absence and an excess of professional detachment.

Within this major theme and sub themes, stories are told about: the intimacy of working closely with individual patients; the skills that are needed to move in and out of closeness; the ability to create a relationship where the patient has choices and is in control of his life pattern.

Titchen, in her observations of Binnie at work, acknowledges that the art of nursing is many-faceted and involves the expert nurse in -

> "taking herself as a person into the relationship and accompanying the person on his/her own very personal journey." (p 4.)

The sub-themes of the second major theme The Facilitator of Learning are:

- starting where the nurse is;
- making professional craft knowledge accessible;
- learning from sharing practice experience.

Within this theme the stories were about: modelling behaviour that encouraged stories to emerge from less experienced nurses; sharing experiences and encouraging others to do likewise; inviting nurses to work with, rather than for, the expert nurse. The following statement arose from a discussion about story telling.

> "I want nurses reading my assessment to be confronted at once with a human being who has a history and a place in society --- I select the relationships, events and experiences that seem to have been most significant in shaping the course of the person's life and will help others to relate to him as an individual, to see him in the context of his social position and background and a part of a social network. These key things will help others to relate sensitively to the patient as they build their own relationships with him." (Titchen 1993 p 7.)

Creating a Context for Stories to be Told

From my point of view, taking a more pro-active role in encouraging novice nurses to focus on each person, their needs and what their lives mean to them, is an essential part of developing that very human relationship that allows a place for caring and healing to occur. This use of the essential humanness of the nurse as a person is the most critical part of the way expert nurses make themselves available to both patients and colleagues. How this is achieved remains within the domain of the individual nurse. However, the ways in which less experienced nurses tend to use 'self' as a therapeutic tool are often unplanned, occurring most often when the usual ways of working seem inappropriate and the nurse chooses to follow intuitive thinking or feeling.

It is in these situations that expert nurses are able 'catch the moment' and teach novice nurses to seek out the meaning in this experience, thus encouraging a more intuitive and reflective response to their patients. The challenge to expert nurses is to develop an environment where less experienced nurses can discuss how, and why, they think and act in a responsive or pro-active ways. This will create the possibility for new knowledge to develop and create new paradigms. (Benner, 1984)

As a result of isolating these two major themes and examining the way the expert nurse manages to be a *skilled companion* and a *facilitator of learning*, Titchen concluded by considering the similarities that are present when the expert nurses is 'Engaging with the Whole patient and the Whole Nurse'. These similarities are about encouraging the development of self knowledge and knowledge of people. I recognise these two components in my own work - they are present as I and my nursing peers develop the field work together.

Having now completed my summary of the core ideas and practices developed by Binnie and linked to Benner's work on the development of the expert nurse, I will now turn to Newman who argues that 'research is praxis' and has a story to tell.

The Nature of Research and Praxis.

Newman(1990), in articulating 'Newman's theory of Health Practice', states that alongside her aim to present an emerging research methodology and its relevance to nursing practice, is the desire to tell the story that brought a sense of reconciliation between original theory and the research that unfolded. This story is about 'coming full circle', from being and acting as a young nurse, thoroughly involved with the patient, to being "captured by the games-like intrigue of the scientific method", before finally realising that "the process is the content"(p 37). Newman begins by explaining that in this context of scientific method she was challenged to:

> "convert holistic parameters of a person's living experience into manipulable artefacts in the laboratory, in an attempt to test some very basic relationship of movement in time and consciousness." (p.37)

Nursing research and self discovery

It seems that the struggle to make research relate to nursing practice went on for some time before -

> "I stumbled onto the conclusion that the important part of my research was the process involved in interacting with the patient."(p 38)

For me, both the research journey that Newman unfolds and the research ideas that she articulates are important. The journey is important because it searches for authenticity and congruence across aspects of being, and the research ideas because they express life as unfolding patterns. Newman's theory is one of expanding consciousness and is based on Roger's theory of unitary human beings. Newman states -

> "Roger's assumptions regarding the patterning of persons in interaction with the environment are basic to my view that consciousness is a manifestation of an evolving pattern of person-environment interaction". (p.38)

The Patterns of Life

This idea of patterning is extended to include a larger undivided pattern of an expanding universe. It is clear that from this point of view both health and disease are part of the pattern of a person's interaction with their environment and developing consciousness. In this model of expanding consciousness the nurse's role is one of supporting and facilitating each person to achieve higher levels of consciousness, through identifying the individual's life pattern and intervening to affirm and enhance it. The aim of Newman's research was to gather information about the evolving pattern that is manifested in each person's experience of health and disease. For Newman the most exciting part of this research was to discover that the process of interaction with the patient, and the pattern that unfolded, was the research. Thus 'research is praxis.' From this point of awareness the original methods of categorising and analysing became suspect, and a methodology consistent with nursing theory and practice became vital.

An important conclusion was reached when Newman realised that -

"The nurse-researcher cannot stand outside the person being researched in a subject-object fashion. The researcher is part of the interaction pattern which is the process of pattern recognition and choice." (p 37.)

This process involves:

- establishing the mutuality of the process of inquiry;
- focusing on the most meaningful persons and events in the interviewee's life;
- organising the data in narrative form and displaying it as sequential patterns over time;
- sharing the interviewer's perception of the pattern with the interviewee and seeking revision or confirmation.

For Newman this process is the content of the research and is coherent and compatible with the way nurses work with patients. It also provides a framework for recognising the unfolding patterns of health and illness within the context of the patient's wider life patterns.

Personal Reflections

There is a degree of complexity and multi-stranded analysis to Newman's experiences. There is also imagery that is captivating, the possibilities being almost beyond time. The rigor applied to finding a way through the competing demands of the research methods was encouraging to me because it resonated with my own difficulties in meeting external demands and having a sense of 'rightness' about my own thinking and acting. The final simplicity of understanding 'research as praxis' allowed me feel confident that what I do as a nurse, and how I do it, is worth researching. I will not include the full discussion of Newman's theory of unfolding levels of consciousness because it is complex and written for a different purpose. It is sufficient to affirm the connection I have made with other expert nurses as I have developed a pathway to presenting my own experiences as a nurse.

I now intend to consider nursing as a caring profession. To achieve this purpose I will present the points of view of two nursing writers, each having a particular point to make about caring as an essential focus for nurses, and each speaking of their concerns for the future of nursing.

Nursing as a caring profession

For most nurses the caring relationship, where the nurse seeks to bring about 'healing', is where the art and science of nursing is found. Benner (1989) says that this relationship intricately binds the act of caring with an understanding of the needs of people as they experience illness. She points out that the skills needed to understand the lived experience of the illness are extensive and require detailed observations and attentiveness. This is caring enriched by education and experience (p. 19). For Benner, theory arises out of, and is therefore grounded in, the experience of caring for patients. Consequently, nurses will often experience conflict between the context in which society chooses to view illness, and the experiences that both nurses and patients have of working together to ease suffering. This desire to care for patients rather than focus on 'a cure' is central to the care/cure dilemma that Benner and other nurses (e.g. Gordon, 1991) identify.

Benner states -

> "In a highly technical society that values autonomy, individualism, and competitiveness, caring practices have always been fragile, but this societal blindness causes those who value technological advances to overlook the ways these advances are rendered dangerous and unfeasible without a context of skilful, compassionate care." (p 399.)

From Benner's point of view both care and cure are to be valued, but care has primacy for nurses.

The Nature and Value of Caring

Benner also promotes caring as the vehicle nurturing personhood. A person is always becoming, always realising their potential, consequently, the burden of health is on the individual. Other people and/or situations can facilitate or obstruct this potential, but the potential exists in the individual. The nurse in developing a caring relationship is responsible for eliciting this potential rather than creating a situation that solicits it. From my understanding this means that the control remains with the patient, where caring does not intrude and take away the choices that are rightly the patients. The quality of the caring relationship, if developed for its own sake, is health-protecting.

In the world of work where nurses are pressed to take on the work of other professions, there is less time to give to the caring aspects of the nursing role. Benner comments that care-giving becomes threatened and is experienced as a loss when one is unable to provide the care that is needed, or when one's care-giver is devalued. This tension and stress that nurses experience when role expectations are not met is expressed in the stories they tell. It is through these stories that nurses share meanings and learn to cope.

Gordon (1991) begins her discussions about 'the crisis in women's work' as applied to nursing by stating -

> "The crisis in contemporary nursing offers perhaps the most devastating example of how America's traditional attitudes toward caring, combined with many women's new goals, have affected the caring professions." (p 143.)

With some passion Gordon describes the conflict that nurses feel as they are required to manage within the new 'market forces' where patients, who are sicker when they come to hospital and sicker when they leave, receive inadequate nursing care because:

> "....caseloads are heavier and patient turnover more rapid, many caregivers have come to feel that the greatest reward for their work----seeing the healing, empowering, life-enhancing benefits of human interaction is now denied them." (p 148.)

Gordon goes on to quote the ratio of nurses to doctors, and says that although nurses are essential to the function of the health services, nursing as care-giving is being undermined as society pressures nurses to focus on tasks. It would seem that England is following this lead,

we now find that the number of nurses qualifying is not sufficient to replace those who are leaving.

In presenting a very strong voice for valuing nursing as a caring profession, Gordon says that devaluing nurses as carers also devalues caring within society. She also sees this devaluing as gendered in that caring is seen as a feminine activity and curing as a masculine one. This brings me to the genderedness of the nursing role and the writers that make clear some of the ways in which this is revealed.

The Genderedness of the Nursing Role.

In discussing the nursing role and the question of gender, I intend to begin by providing my own understanding of how the expectations placed on nursing are gendered. I will then introduce Marshall's (1989) work on occupational stress from an ecological point of view in which nursing is one of the occupational groups included in the study. This work will provide a broad picture of the stress endemic within the context of nursing practice. It will also provide the setting for considering the ways in which gender operates to reduce the nurse's power. Finally in order to bring a practice point of view to the issue I will refer back to Gordon and introduce Schachtel as further evidence of how the nurse's role is gendered..

Role conflict in nursing

The role that nurses are 'given' by society is often in conflict with the way nurses perceive their role to be. Nurses are continually struggling to cope with conflicts between the expectations of others, their own internal voice of 'duty' (Benner 1989), and the ways in which they intuitively and rationally would wish to act. These conflicts are becoming more overt as nurses have greater access to higher education and are more able to write about what they do.

Marshall (1986) in seeking to understand stress from an ecological point of view focused on occupational groups where stress seemed to be endemic. Stress in this piece of work was seen as being "part of the system and not attributed to any one individual" (p.282) and an 'ecological profile' was used to examine occupational stress. Nurses were selected as one of the occupational groups to be studied, and when the ecological profile was applied it was found that stress arose around role expectations, especially with regard to the patient or public. The ways in which nurses cope with this stress was also a part of the study, and it is suggested that nurses develop defences which in turn become occupational norms. These norms sometimes influence the organisation to the degree that they are embedded in the structures.

The key to the whole process seems to be the expectations that society has of nurses, and the ways in which healthcare settings are developed and managed to meet society's needs. Nurses are seen as the carriers of society's anxieties, ones that are not easily resolved like death, birth, illness, disability and deviance. (*I would suggest that in western society women also carry these anxieties for the family and the community*) In carrying these anxieties nurses

experience separation and isolation. It is this separation and isolation that can lead to protective social mechanisms in order to cope with stress. Marshall's work generates evidence towards the idea that nurses choose to manage within an organisation in a way that de-humanises, sees patients as illnesses and nursing as tasks to be done. This maybe so if one takes an organisational point of view and assumes that there is some sense of control over ones destiny, particularly if one is seen to be in a position of authority.

The Stress of Conflicting Demands

My work with nurse managers leads me to believe that they are more isolated and separated, not only in relationships, anxiety associated with illness, disability and death, but also from their own nursing colleagues because of the burden of responsibility. The idea that nurses cope through sharing responsibility with other nurses, and through losing their sense of self, has some validity. Sharing the burden of being responsible for society's ills, and denying one's own values or sense of self, allows the individual to screen out the emotional responses that are attached to human frailty and human disaster. This denying of human feeling and connectedness may relieve the intensity for the moment but is acknowledged by nurses to be damaging to a sense of integrity. The fact that this unhealthy way of coping, which is in the main placed on women, is much more sinister. The evidence that women take up the stresses and anxieties of society is not unfamiliar, and the way we construct family life is mirrored within the health care services. It maybe that the anxiety, stress and coping mechanisms, that are a part of the nursing culture, can be recognised as the organisation's response to this agenda. I would question whether this evidence is 'true' for nurses.

My experience has been that nurses have another level of 'coping' which is about understanding, at an intuitive level, the stress they and their colleagues are feeling. It is true that this intuitive level is submerged under the need to 'do', and 'keep control' over very fragile situations, and consequently leaves little space for a healthy expression of anxiety. However I have also experienced the way in which this understanding is expressed in lifelong friendships, story telling, and camaraderie, when tasks are completed and nurses are relaxed and together. Although nurses are aware of this 'other' world, until quite recently it has remained.

The dilemma for the nursing profession is that nurses are unable to change their own roles without confronting the expectations of society and the context in which we practise nursing. This seems to mirror the position of many women in our society where opportunities are available but the expectations of others mitigate against the kind of change that liberates the mind and spirit. There is also something about gendered life strategies that render women invisible and men visible; maybe it is the genderedness of occupations that favours the masculine or the feminine life strategy.

Gender and power

There is a power and an intensity in Gordon's affirmation of the caring role, and her choice of nursing as a career rather than medicine. The irony of this 'choice' is that to rationally and

consciously choose a role that expresses the feminine is to choose subordination to roles that express the masculine. This outrage is encapsulated in this statement from Gordon:

> "The idea that caring is an act of assertion, strength and affirmation of course, contradicts all of our comfortable notions that caregiving work consists of little more than nodding sympathetically emptying a bedpan, writing letters on a blackboard or diapering a baby's bottom."(p.152)

In valuing her own role as a nurse, Gordon tells how the caring role of nurses is trivialised in favour of glorifying doctors, both at work and in the media. This denial of the essential feminine part of nursing, according to Gordon, is not made any easier as more opportunities become available for woman to enter male dominated professions. Young women doctors are faced with denying the nurturing, inclusive part of themselves, in favour of developing the individualistic competitive part.

Gendered Professions

As I explore the role of nursing in society, I am more aware of the way in which the changing roles of women are mirrored in the changes that I experience as a nurse. The management of nursing has been challenged, the education of nurses is now part of higher education, and nurses are beginning to challenge the role that has been imposed on them. Many more nurses are now able to cope with anxiety in ways that are more healthy. By asserting and using their skills and knowledge, they are able to increase their personal power. These changes are gradual and sometimes resisted within nursing because of the implications of change and the shift in the balance of power between the sexes. This struggle to shift the balance of power is also felt by other women practising in the health field and is worth spending a little time pursuing in order to place nursing within the context of gendered roles.

Schachtel (1986) in her role as a psycho-analyst asks the question,

> "Do gender role differences affect how we, as men and women analysts, experience our work role?" (p 257.)

In seeking an answer to this question she discussed with student analysts their experience of being in the analyst role and being supervised. She found that expectations associated with gender were present both in relation to others (patients, colleagues and supervisors) and in the internalised ways of interacting. Women students, in particular, were more concerned about what to do with their feelings, finding difficulty in think about them. Male students, on the other hand, did not talk about their feelings but focused on formulating ideas. Schachtel's conclusion was that the role of analyst is first and foremost male because the formulation of ideas is a valued skill for the analyst. This led to the view that women are required to fit the established role without any cognisance of the different challenges facing them, or the different ways in which these challenges will present themselves.

For me, as for many other nurses, nursing requires intelligence, responsiveness and an ability to take action with, and for, others. Taking a caring role in relationship to others is about managing the complexity that is generated when illness becomes uncontrollable for the individual. This role leans very much towards the feminine. However, nurses may need to acquire some of the masculine strategies to develop their role in a more assertive way and address some of the inequalities within the health care team.

Group Work and Peer Relationships.

Nurses work in health care settings with other health workers, the most significant relationship within this context being that with the doctors. Nurses learn to develop this relationship in order to provide care to patients and manage the healthcare environment. The role that doctors require of nurses is sometimes in conflict with what nurses consider to be 'good nursing care' - this is the 'care/cure' conflict. To manage this conflict, and other dilemmas that are part of this setting, nurses need to work together and support each other. I have discussed previously the stress that is left unresolved when nurses are unable to develop healthy coping skills (Marshall 1986). I now intend to present some of the ways nurses have tried to address this difficulty, although they may have defined it differently.

Peer support and peer appraisal are two concepts that I link together because support alone does not, in my experience, achieve the changes needed for nurses to cope more effectively in the workplace. Nurses need to be able to give each other constructive feedback if they are to make creative and positive changes in practice and in their relationships with other professionals. This feedback should occur within a supportive environment where trust, honesty and risk taking are encouraged. Before I discuss my own experiences and ideas about this aspect of nursing, I will present the works of Kavanagh (1989) who researched the social support networks of nurses, and Liberatore et al (1988) who worked with nurse managers to explore a group approach to problem solving.

Peer support and appraisal

Kavanagh begins by commenting that interpersonal space and distance characterizes nursing. She continues by saying -

> "Nurses form a predominantly female but otherwise heterogeneous group with widely varied socialisation histories, socio-economic backgrounds, educational accomplishments, ideological approaches, role interpretations and personal lifestyles."(p 226)

This being so the questions then arise:

- Do nurses meet together and enjoy each others company in or out of work hours?
- If they do, or if they did, would there be any positive gain?

Kavanagh(1989) studied the social support networks of 35 psychiatric nurses, inquiring into both private and public roles . In this study social interaction was defined, and boundaries were set to reduce the complexity to three orders of social relationships. These were structural,

categorical, and personal. Structural included the hierarchies within the institution, categorical the social features of class and ethnic group, and personal included both formal and informal transactions across acknowledged structures and boundaries. The focus of attention for this research was the ideological variation, interactive patterns, perception of stress, and support and coping strategies. Attitudinal surveys were collected from 90 members of the nursing and therapies staff and from 35 psychiatric nurses of at least four years experience. All were given focused open-ended interviews.

This piece of research re-affirms the findings of Marshall and provides evidence of significant barriers to practice-level relationships amongst nurses. In this study nurses found themselves unable to develop relationships that were supportive and ongoing because of the changes in work patterns, the inability to develop any sense of belonging to a team, and the way in which work was distributed. Realistic expectations for the development of effective networks requires management of these. The expectations of nurses within the organisation is also recognised as a block to effective peer support.

Kavanagh reached several conclusions at the end of this research:

- nursing is facing a struggle for autonomy, status and recognition;
- the image of nursing is traditional, non-feminist, invisible and non-assertive.
- nurses experience prohibitions engendered by strong cultural values and their expression within the social norms of hospital and medical systems.

The other inhibiting factors such as reward, promotion, mass production of services and survival level competition, were also identified. However the key statement is:

> "Despite significant progress, nurses and women, like other minorities, struggle against strong competition to become more than weakly influential; there is a need to examine nursing itself." (p 232)

Group work in practice

In contrast Liberatore et al (1988) studied the usefulness of small group-work settings for developing peer support for nurse managers. The principles of group functioning were used to reach solutions to common problems. The rationale was that:

> "In a small group, each person is able to relate to every other group member. There is interdependence among them because all are in management positions."(p 68)

It was expected that within this 'small group' culture nurse managers would be able to contribute to the problem solving and reach commonly agreed decisions.

> "Problem solving is defined as the process which attempts to identify obstacles that inhibit accomplishment of a specific goal."(p 68)

The focus of this piece of research is on common issues selected by the participants and the results they managed to achieve. The expectation was that the participants would select issues that had meaning for nurses in terms of clinical and management practices. This was

not the case, the participants focused on very practical issues such as lack of materials to do the job, inappropriate methods being used, shortages, improperly functioning machines and inadequate manpower. One could say these were very 'safe' issues, where the rejection of a solution would not be seen as a personal rejection. Most of the solutions were rejected because of: the cost; too time consuming; too risky; insufficient support. The reason given for the lack of resolution can be summarised by the following statement:

"---reaching agreement was hindered by persistent differing opinions." (p 72)

This for me is the important outcome of this exercise because the idea of bringing nurse managers together as a group has both positive and negative possibilities. Positive because nurse managers often find themselves alienated from their own nursing colleagues and in need of support when difficult decisions need to be made. Negative because to bring people together who work in competing environments does not easily foster support and mutual goals. The focus was on management not nursing, consequently the task was more important than the process and the opportunity was lost for nurses to learn how to manage without 'standing outside' nursing. The skills learned as a nurse are as applicable to the nurse who manages, as they are to the nurse teacher or the specialist nurse. Nurses who remove themselves from nursing are often regarded by nurses as 'them' and not 'us' - loosely translated as 'the management', or 'the College'. The fieldwork in Part Two of this thesis brings to the surface these dilemmas for nurses who manage and nurses who teach.

Coping with Conflicting Agendas

The two articles above (Kavanagh 1989 and Liberatore 1988) are representative of some of the effort that is being made to encourage nurses to be open about the stress they encounter in their work, to share this and find ways of working that will increase positive outcomes. Both writers have produced some valuable information that informs the ways in which nurses conduct their lives. Two major issues are surfaced. The first is that nurses look for peer support and appraisal both in and out of the work place, and the second is that nurses are unable to disclose and work together when other agendas are not made overt.

The first issue is about the culture and climate of institutions and the powerlessness nurses feel in changing this. Again this is about being in a gendered occupation and often personally invisible. The second is about managing the environment and supporting each other to solve problems affecting the way nurses manage nursing care. There is an energy, and sometimes an imperative among nurses, to solve the problems facing the organisation and the profession. Conflict is often experienced when the demands of the profession for change are in opposition to the demands of the organisation for stability. If the focus is only on problems as they arise, and the power base is left unchanged, then nurses are unable to lead the change. They can only influence when opportunities arise.

It is also important to note that nurses attend meetings with the 'voices' of others more dominant than their own. Often nurses they do not speak on their own behalf but are charged

with the wishes and concerns of others. In this kind of setting the voice of the individual nurse is rarely heard unless she/he is within a peer group committed to personal and professional support. Meetings held within the organisation to solve organisational problems tend to focus on 'safe issues' where the cultural norms can continue to operate. Unless there is agreement to create a different agenda, where trust and openness is affirmed and nurtured, disclosure about individual experience will not occur.

Nurses, as they work with their patients, are able to demonstrate their interpersonal skills and knowledge. They are able to facilitate disclosure in order to find new and powerful solutions to difficult personal and interpersonal problems. The ability to engage at this level of skill does not necessarily transfer to interactions with other colleagues or the wider organisation. There is obviously the potential for this to happen, however the context in which health care occurs does not generally foster it. The risks attached to being open and honest about what one thinks and does results in nurses, in particular, taking a guarded approach to protect their own vulnerability.

Creating a climate of trust, a place to acknowledge and express powerful emotions, and to resolve differences, is in its infancy in the organisations where nurses work. As Marshall states-

> "Unless the total system changes, adaptive coping at one level typically increases experienced stress at the other----stress is 'in the system' and cannot meaningfully be attributed to any one part of it alone. Stress is a system characteristic, even though it is primarily expressed through individual experience."(p 282)

If this is to be taken seriously, then nurses will need to develop their roles as clinicians, teachers and managers in ways that modify the organisation and thereby influence the way others perceive nursing. For nurses to confidently practise their professional caring role it is necessary that the colleagues they work with support this role.

Conclusions

This chapter has provided a review of nursing from the writings of expert nurses, other social scientists who have studied nurses and nursing, and my own thoughts and experiences. Much of the research and preparation for this chapter was developed as I participated in the two field work groups. Therefore it provides a background for understanding the way I and my nursing peers managed the fieldwork in Parts Two and Three.

The next chapter gives an account of the research methodologies I considered and then pursued because they seemed to be compatible with my understanding of nursing. They also gave a stronger frame to my intentions to develop an inquiry group.

Chapter Three

Introduction

This chapter describes the beginning of the research process and is designed to take the reader from the point where I formulated my ideas about the research questions, to the beginning of the field work. The field work was centred on a co-operative inquiry group and the participants were all experienced nurses. The journey from beginning this research degree in 1990, and beginning the field work in the spring of 1991, is contained in this chapter. I began this process with two questions in mind, they were:

- what questions do nurses ask about how and why they work together?
- what research methodologies are congruent with nursing practice?

To answer the first question I consulted with my colleagues and this is contained in Chapter 4, 'Preparation for the Field work'. To answer the second question I reviewed my own experiences and consulted the writings of people who were exploring qualitative research. The results of this search provided me with methodologies that were in harmony with the nursing process, and which I believed to be academically sound. The literature that informed these choices of methodology was a major part of the discussion and formulation process. Before commencing a description of this search it is important that the two major decisions I made before entering the research process are acknowledged. One was about the membership of the field work group and the other about making my work 'public'.

Clarifying the Research Project.

In thinking about the membership of the field work group, I considered the relative value of recruiting participants from different work contexts, and of inviting a group of nursing colleagues to join me in my work. I decided that I wanted to work with a heterogeneous group of senior nurses involved in different health settings. This I believed would encourage a wider perspective of nursing and, hopefully, promote a more challenging debate. In order to make the project attractive to this wider group of nurses, I knew that I would need to develop a framework for the field work that resonated with nurses from different fields. In essence I was seeking to find the common recognisable thread that this wider group would recognise as nursing.

The second decision was about whether I wanted to keep this research project 'private', and to work on it in my own time, or whether I wanted to open up my concerns and ideas to a wider audience. I thought about the implications of this choice for some considerable time and I decided on the latter. My decision was based on my commitment to myself to make more available to others the way I worked as a nurse, and to encourage other nurses to do the same. This choice meant that I would need to travel the path of applying to the Nursing Ethics Committee for permission to research within the Health Authority. This made my work public, and also required that I provide some feedback to the authority at reasonable intervals. As a consequence of this decision, a series of events occurred that are a part of this research because they challenged my

intent and highlighted for me the need to research in a way that truly reflected the ideas and practices of nurses.

In order to meet the Ethics Committees formal requirements, I also gained support from a nursing colleague who was at the final stage of her PhD. She gave me her perspective on what was expected, and together we designed and completed the research proposal. This was not an easy task, as I felt I had to try and fit my ideas and purposes into the design that we both agreed would be appropriate. The final paper went before the committee and came back to be rewritten. A clearer outline of the purpose, the methodology, and the research subjects was requested. I was invited to seek an interview with the chairperson to discuss further before submitting a revised proposal.

I took up this offer and used the opportunity to both hear more fully the concerns of the committee and to explain what I had in mind. I went to the interview feeling rather marginalised, wondering how I was going the convince the chairperson that developing a co-operative inquiry group of senior nurses was academically valid as well as being important for nurses and nursing. It became clear during our discussions that one of the members of the committee was familiar with this kind of research and would prefer that I made it more explicit in my proposal, rather than confuse it with other ways of doing research. I negotiated time to think and consider, and to talk with my supervisors before rewriting. I believed that this was necessary if I was to clearly identify an appropriate methodology and an outline that met the Ethics Committee's requirements.

Using Supervision to Clarify the Boundaries.

The supervision session with Judi Marshall and Peter Reason took place at Bath University. My intention for this session was to get some clarity about my thoughts and ideas, particularly on the kinds of research that involved subjects as co-researchers and researchers as co-subjects. I had some relevant literature, but I was not really clear about the appropriate design for the kind of research I had in mind. I was also quite hazy about what my role would be within the research process. I had experience in working with a range of different groups, from psychotherapy to self help groups, therefore I needed to be clear about the differences in working with a group of researchers.

My supervision session at Bath passed through several phases of inquiry in which I recorded the dialogue using a tape recorder. After the supervision session I transcribed the dialogue and identified the phases that highlighted particular issues. This provided the focus for my attention and energy, directing me towards clarifying my intentions and purposes. As a consequence I was very clear that the research field work would be best achieved by setting up a nursing research group to produce the main body of research data. The clarity I achieved at this point provided the catalyst for opening up ideas, concerns, perceptions and questions, engaging me in the process of developing a sense of inquiry into my own practice as a nurse. From this basis the research proposal flowed and I was able to write in a way that was acceptable.

I had taken the first 'public step'. I was committed to following through my proposal and I was much clearer about how I would initiate and manage the 'field work'. Deciding on a process for initiating and facilitating the research group, coherent with my own ways of acting, thinking, and being, was the next step. I wanted the field work to fit with the way nurses work and interact together, and if I was to be authentic in facilitating this activity, then I needed to consider my style of working within a group context. These issues informed part of the search for an appropriate methodology.

There are three aspects to this search, each is equally important and will be considered separately. They are:

- knowledge induced from my own experiences;
- theoretical ideas and practices that inform Methods;
- Developing an appropriate methodology.

I will now pursue each one in terms of developing the methodology for the field work.

Knowledge Induced from Experience.

I experience nursing as an interpersonal activity involving relationships with different people in different situations. Patients are primarily the focus of the nurses attention, however relatives, visitors and other health workers also claim attention and concern. Each nurse is a part of many dyads, triads and groups, and is pressed to adjust and accommodate to different languages and expectations. This pressure of demand can cause the nurse to be distracted and the patient to be neglected. Nurses have learnt to cope with this difficulty by establishing particular patterns of work and by helping each other when pressure arises. These patterns of work ensure the essential tasks are achieved and that both staff and patients are safe. There are two particular ways of working that have been formalised and are of particular interest to this research. The first is the 'hand over', where nurses transfer the care of patients between one group of nurses and another at the end of each shift. The second is the nursing care process that guides the nurse through the interactive process with the patient, from assessment to discharge.

The 'handover' is both functional and a kind of ritual, consequently the agendas that it meets are not always clear. It is a place for giving information about the day to day activities that need to continue through consecutive shifts. It is a space for nurses to exchange ideas and stories about their patients, and the problems or difficulties that are both resolved and unresolved. It is also a place where nurses can give each other support and feedback about the effectiveness of nursing and medical interventions. It is a place where nurse can 'let go' of the responsibility for both staff agendas and patient care. The handover session is the only time when nurses can be together as a total group. This familiarity with, and reliance on, working within a communal frame is an important basis for developing an inquiry group.

The nursing care process is a cycle of events that structures the nursing management of each patient's nursing needs. This refers to the continuous cycle from referral and assessment to review and discharge. The process incorporates nursing work that is independent and prescribed by

qualified nurses, nursing work that is dependent on the medical intervention, and nursing work that is interdependent and relies on co-operation between disciplines. My experience of the nursing process as prescribed by the nurse is of a cycle of events that requires knowledge, skills and experiences to be brought together in order to meet the needs of patients. This cycle involves assessing, problem solving, prescribing, intervening, observing and evaluating. The outcome of the evaluation leads into further problem solving and the cycle begins again until the patient has no need for nursing care. Newman (1990) talks of the nursing process as being a research process. This may be so in some instances where the nurse is attuned to ideas about rigor, however, whether that is true or not, the discipline of the nursing process is useful as a familiar basis for introducing the research cycle.

Theoretical ideas and practices that inform Methods.

The theoretical ideas and discussions that have influenced the development of an appropriate methodology fall into two main areas:

- theoretical ideas and practices from my past experiences;
- theoretical ideas and practices from chosen readings;

I intend to present each separately.

Ideas and practices from my past experiences

These ideas and practices are rooted in my experiences as a nurse teacher in New Zealand. As I have already introduced these experiences through 'story telling' in chapter one, I will now focus on the experiences that have informed the way I set up and facilitate group work. The roots of my learning as a group participant are based in the 1970's zest for personal growth, a time when I was involved in the 'T' Group Movement. The 'T' Group or Training Group is an intensive small group aimed at promoting personal growth through group participation in self awareness activities. It is intensive in terms of the demands on individuals to:

- self-assess;
- self disclose;
- give feedback;
- risk take;
- validate the behaviour of others (Jones, 1972)

My experience of managing groups arises out of my understanding of groups as a vehicle for personal learning. I am a product of those times. However, using group work to facilitate the development of interpersonal skills with students required a more task oriented approach. It is the development of this approach that I will present as both knowledge and skill to take forward into the fieldwork.

The challenge at that time (New Zealand in 1974) was to assist students to develop the interpersonal skills needed to meet the requirements of working with both patients and staff. My perspective was that if students were to communicate effectively with people who found communication difficult, and sometimes impossible (staff and patients), it was important that they

developed confidence in a wide range of interpersonal skills. This I realised required the students to experiment with communication in an environment that supported risk taking. Effective communication needed to be learned in a 'live' situation where skill building required practice and personal discovery. I turned to Pfieffer and Jones (1973) 'A Handbook of Structured Experiences for Human Relationship Training' as a resource for building a programme to address these skills. This training resource provided me with the necessary tools to teach students particular skills and abilities using the techniques of experiential learning.

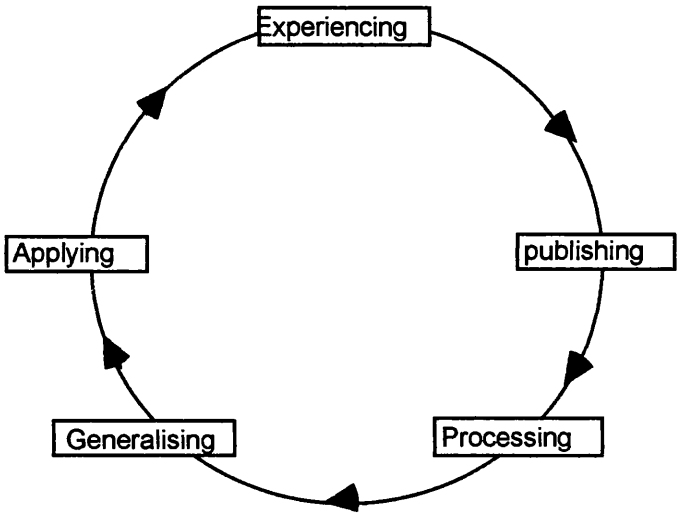
Experiential Learning

This way of teaching and learning stimulated and supported the students' ability to make sense of their experiences and led to personal and group discovery that valued both individual and collective understandings of these experiences. The ability to connect these experiences within the 'classroom' to those in the workplace was also encouraged and pursued. The design skills developed at that time are ones which I have continued to use and adapt to differing challenges. They included:

- goal setting;
- pursuing individual sense making;
- sensitivity to participant response;
- sequencing;
- creating opportunities to test 'understandings';
- collaborating with other facilitators;
- transfer of learning to the workplace.

The experiences relied heavily on investment and involvement by all participants, consequently this was a learning experience for all of us. The content of each experience focused on issues relevant to the group, or a particular individual. Processing the data generated by the group was the central core of the activity because it provided the setting for clarifying the ideas, feelings and questions that are a part of learning. This in turn prepared each participant to make a connection with workplace situations.

The following diagram illustrates the experiential model that became familiar to me: (Pfieffer and Jones References Guide)



This diagram represents a five step model based on the premise that:

> "experience precedes cognitive learning, and the learning, or meaning, to be derived from any experience, comes from the learner him/herself." (p. 4)

This way of learning was liberating for the students because there was freedom to affirm particular styles and strengths. I also gained a method of teaching that was authentic for me as a teacher and in harmony with what I believed to be the basis of nursing as a caring profession - the ability to communicate effectively with others.

Times have changed since then and I have learnt in many other ways to change and become more aware. However I remain committed to the belief that each individual's experiences are unique to him or her, and that as a teacher my role is to encourage this learning to occur in a climate of support and honest feedback. There is a degree of chance in every experience and no one can predict what each individual will learn. However, keeping this in mind, I have found that providing a setting for experiential learning where the individual's experience is validated, creates a potential for learning that goes beyond that initial situation. The five revolving steps are a part of my 'tool box'. They are not rigid and do not restrict my ability to flow with what is presented, or to adjust to the mood of the participants.

Each of the five steps have a particular focus and provide the context for a particular transaction between the participants. These steps are as follows

- setting up an experience that will involve the participants in an activity which is chosen for its ability to provide a basis for the learning process;
- encouraging each participant to 'publish' or share their reactions and observations with others who have also experienced or observed the activity;
- extending this sharing process to include the dynamics that emerged during the activity through exploration and evaluation;

- deriving some generalisations or principles from the activity that provide connections with other experiences;
- applying the ideas that have been generated to a new experience and evaluating this new experience through presence in it and reflection.

I believe that experiential learning is purposefully immersing oneself in a situation in order to learn through that experience. Therefore, I take every opportunity to develop such situations at work and with colleagues who are having difficulties with being 'heard' and understood. For me, it is very important to be mindful of each person's vulnerability as they take up the challenge and participate in an experience that has the potential to arouse emotions and memories. The value of this kind of intentional learning is inherent in the act of consciously placing oneself in a learning experience, where the potential is present to expose patterns of interaction and thinking that awaken unconscious conflicts.

This new knowledge can provide the impetus for changes in self understanding and in the interpersonal qualities of one's life. Whether these experiences are open to being shared with others lies very much with the individual to choose. Making overt this openness to choice is an important part of learning in this way, because leaps in knowledge and understanding often need time to make sense of and require confidence to speak out about. In these very personal situations, the key role of the facilitator is to ensure that every member is aware of the choice, and that a context is created that supports risk taking.

Experiential learning has been with me a long time and I have tested it out with different groups of people in many different settings. Each time I have learnt more about myself, and others, and the way in which the context can influence what is learnt. In setting up a Co-operative Inquiry group as a 'laboratory' for the field work I drew on my experiences in groups to facilitate and to manage the research process. The next section will focus on the readings that have influenced my choice of research methodologies, and how I planned to implement them.

Theoretical Ideas and Practices from the Literature.

Before I highlight some of the reading that provided the framework and the methods for managing the field work, I need to present and discuss some of the readings that enhanced and clarified the ways I worked and thought about the world. To do this I will begin with the paper written by Guba and Lincoln (1990) in which they discuss and critique post positivism and critical theory in relation to positivism, and then present constructivism as an alternative paradigm to positivism. Having presented this work I will consider the ideas and methods in this writing that connected with my own.

Naturalistic Inquiry

Guba and Lincoln begin by asking the question 'Can there be a Human Science?' and in finding an answer to this question promote Constructivism as an alternative. The argument and the evidence that they provide in coming to this conclusion were interesting and challenging. I was not sure that I fully understood the intricacies of their argument, however it helped me to develop a

basis for my own thinking about research. Their critique of post-positivism raised important issues for me, and brought to the surface ideas and theories that I resonated with. Their treatment of these ideas and theories left me wondering at times because I have a resistance to discarding ideas and ways of making sense that seem compatible with my own. To be more explicit and purposeful, I will focus on particular points that contain much of their argument, and then provide my own sense making.

Guba and Lincoln define science as 'our need to know'. They go on to say that conventional science has assumed the form of positivism and is now being challenged by post-positivists, critical theorists and constructivists. In providing a way of comparing these challenges with positivism, Guba and Lincoln pose three fundamental philosophical questions.

- What is there that can be known?
- What is the relationship between the knower and the known?
- How can one go about finding out?

These three questions may be termed respectively the ontological, the epistemological and the methodological. The answers to these questions are the 'basic belief systems' of each theoretical position. These are the starting points, the 'givens' that determine what inquiry is and how it should be practised They go on to say that the rules of science that are extrapolated from these basic belief systems are human constructs and therefore cannot be ultimately proven or disproven. From this point of view the search to find out 'how things really are' is a false one.

To make the point more graphic, Guba and Lincoln go on to present each 'basic belief system' of positivism, post positivism, critical theory, and constructivism within the philosophical framework of ontology, epistemology and methodology. This invites the reader to compare the way in which each belief system is unfolded into research actions. The positivist position clearly objectifies the subject, subverting their interests to those of the inquirer. Post-positivists believe that there are some imbalances created by the positivist paradigm. These imbalances are between:

- rigor and relevance.
- objectivity and subjectivity.
- precision and richness.
- elegance and applicability.
- discovery and verification.

In their terms, the answer would be to redress these imbalances through devices such as: critical tradition (literature), self revelation ('coming clean'), critical community (journal editors and referees) and meta-analysis. Post-positivists continue to assert that manipulative experimentalism remains the ideal inquiry form, conceding only that adjustments must be made because of real-world constraints (page 140).

Critical Theorists acknowledge that because paradigms are human constructions they are not impervious to the influence of human values. Values, they claim, enter into the inquiry at such points as:

- the choice of problem selected for study;
- the choice of the conclusions to be drawn;
- recommendations to be made.

Consequently, they consider that nature is constructed through some 'value window' because it is impossible for us to see nature as it 'really is'. Nature, they say, cannot be seen as it "really is " or "really works" (p 141). Guba and Lincoln, in responding to this claim, point out that although critical theorists acknowledge an interaction between the observer and the observed (a 'subjectivist epistemology' in other words), they implicitly retain a 'realist ontology' or a belief in a 'real reality' that can be uncovered. This disjunction is, to them (Guba and Lincoln), a fatal flaw in the approach and does not create a real alternative to positivism.

Constructivism is presented as an alternative paradigm which affirms that no 'ultimate reality' exists independently of the knower, but rather is created through dialogue.

The constructivists position is that:

- realities exist in the form of multiple mental constructions, socially and experientially based, local in their form and specific, and dependent for their form and content on the persons who hold them;
- the inquirer and inquired-into are fused into a single (monistic) entity. Findings are literally the creation of the process of interaction between the two;
- individual human constructions are elicited and refined hermeneutically, and compared and contrasted dialectically, with the aim of generating one (or a few) constructions on which there is substantial consensus.

This ideological position is translated into action in the world through determining the constructs that exist in a particular field of study, and bringing them as near as possible to a point of consensus. The methodology involves the hemeneutic cycle of inquiry which is a process of developing informed constructions within the constraints of both the information available, and the context of the inquiry. As more sophisticated constructs emerge they may replace existing constructs, but they are not seen as more true, only more informed. The aim of the process is to transform the human mind, not the "real world", by inviting each person in the inquiry cycle to hear the constructs of others and make clear their own, so that a degree of consensus is reached between the participants.

Conclusions

In reading this paper I compared the belief systems presented with the way I understood and made sense of the world. I realised that although the argument presented was valid, I did not feel it necessary to discard the way critical theorists develop their research methods. I could hold the different perspectives of critical theory and constructivism in my mind if I reflected on different aspects of my interaction with the world. The analysis of the critical theorists' point of view provided another way of examining my values and the way they influenced the research so far, particularly with regard to my choice of problem for the field work.

I could acknowledge that my choice arose from the value I placed on nursing and my need to transform the way health care is provided, especially by nurses. I was also aware of a passion for fairness and respect for individuality that seems to mirror the criticism that is laid at the door of critical theorists by Lincoln and Guba (1990).

> "If the aim of inquiry is to transform the (real) world by raising the consciousness of the participants so that they are energised and facilitated toward transformation, then something other than an experimental, manipulative methodology is required". (p.142)

I had a 'gut' feeling that this was true but I was not quite sure what it meant for me. The continuation of this critical analysis confronts the idea and purpose of acting in the world and that is often what I saw myself doing. Although in acting in the world I did not seek to eliminate 'false consciousness' and draw people towards a particular point of view, I did make judgements about where I focused my energy and to what purpose. I will revisit both critical theory and constructivism later in the thesis when I describe my preparations for the field work, because some of the values that influenced my search for a methodology straddle the two perspectives of effective human interaction and shared meaning making. From my understandings of the discourse presented by Guba and Lincoln I formulated the following concepts to take forward.

- In any research inquiry there are imbalances to be addressed between; rigor and relevance; objectivity and subjectivity; precision and richness; elegance and applicability; and discovery and verification.
- I have certain values that are important to me and in fact are basic to my own personal integrity. I need to be open to discussing these and also open to others' value positions.
- The sense that 'reality' is created by our interaction with each other within a particular context. This can facilitate consensus, as well as the acknowledgement that each individual separately constructs meaning.

The process of teasing out the core ideas that were coherent with my research intent gave me a sense of what was involved in pursuing qualitative research. However this process raised more questions - it did not provide me with the necessary link between thinking about ideas, and creating ideas through acting in the world. Nor did it help me to connect with research in a practical sense of noticing the knowledge in the act of doing. I found that Heron (1981) helped me bring some order into this complexity of 'learning to know' and it is his ideas that I will now present.

Co-operative Inquiry

In presenting an experiential research methodology, Heron delineates three ways of developing knowledge. These are defined as:

Propositional knowledge - knowledge about facts or truths as stated in propositions: it is entirely language dependent.

Practical knowledge - knowing how to do something as exemplified in the exercise of some special skill of proficiency.

Experiential knowledge - knowing some entity by direct face-to-face encounter with her/him/it.

These 'kinds' of knowledge are part of a research process that involves the subjects of the research as co-researchers. Heron names this research process Co-operative Inquiry.

In this model, each person involved is both co-researcher and co-subject. Each is involved as co-researcher, contributing to the research propositions at all stages from the working hypothesis to the research conclusions, and as co-subject, being fully involved in all stages of the research action. Heron is very thorough in his explanation of the nature and flow of ideas between the various ways of knowing within each individual, and between individuals. However, the most important understanding that I took into my own research was the clarity about the ways of knowing and how each contributes to the research cycle. Heron (1981) applies these different ways of knowing to the four stages in his research cycle.

The first stage involves the co-researchers discussing the initial propositions and agreeing how these ideas and models can be developed. This also involves agreeing the tools and methods to be used. The second stage is where the research participants encounter each other and the research situation. This involves experientially testing out the ideas and models by entering into the co-subject role. The third stage is when the participants decide to move into the field of practice to encounter and experience the situation as co-subjects. Knowledge at this stage is practical and is achieved by an openness to situations so that learning takes place through encounter and experience. This stage relies for its acuteness on the ability of the participants to 'bracket off' their latent propositional knowledge so that they are fully engaged in the new experience. Stage two and three are repeated so that sufficient data are available to move to stage four. The fourth stage returns the co- researchers to propositional knowledge where they look for themes, recurring patterns, and further hypotheses to help to clarify and draw conclusions.

These ways of knowing felt coherent with the way I wanted to work with a group of experienced nurses, taking care of both the development of the research as a fieldwork project, and the knowledge about nursing that would emerge from the process. These ways of knowing and how they might be managed within a research cycle were both challenging and appropriately connected with my experience of nursing. However, as the actual methodology is centred on being inwardly aware and conscious, this did not sit comfortably with the way in which nurses, who do not already know each other well, would want to work with each other. Also, the way in which the steps within the cycle are articulated did not feel coherent with the way in which I experienced the interweaving of ways of knowing. I did not feel that I had Heron's clarity of purpose when working with people in a group setting. My style was to move between the layers of being, feeling and doing in a way that creates cohesion within the group and a sense of choice for the participants. The research cycle for me needed to have direction but also a life of its own.

Conclusions

Reflecting now in writing this thesis, I realise that in preparing for this field work much of what I understood as 'research' had been about propositional knowledge, knowledge that involved ideas

and theories in the abstract. When I function as a nurse, much of what is expected of me is of a very practical nature and highly visible - fetching, carrying, co-ordinating, recording, reporting, fixing, tasking and so on. My observable knowing is practical and about the task to be done. However, when I think about what nursing is to me now, I find that under the practical, visible, task there is both intuitive and propositional knowledge. The former is generated from experiences and the latter arises out of making sense of these experiences. This important knowledge has developed increasingly over the course of conducting this research.

The world of experience is complex and for me does not sit easily within a process that is clearly defined. However, the way in which Heron presents the subject and researcher as an equal partnership was coherent with the way I saw nurses as working towards equal partnership with patients/clients. It was my intention to research with my own nursing peers and I did not see the skills of self awareness needed to use Heron's model fully as being readily available to most nurses. My experience of helping nurses to gain skills in interpersonal competence, through role play and video work, made me aware that this way of working is new to many nurses. Nurses do not have the models and personal experiences needed to manage the personal issues I believed were a necessary part of Heron's model of experiential learning. Coming to terms with this realisation led me to consider other research cycles that, from my point of view, were more compatible and sensitive to the way nurses work together. The research model that I chose, or developed, needed to match more easily the way nurses thought about, and worked with, the nursing process. A model that would lead more easily into developing the skills of self awareness, interpersonal effectiveness, and group work seemed to be important at this point.

The Research Process

Rowan (1981), in his complex discussions about the researcher-subject relationship provided a very workable and practice-oriented explanation of the research cycle. Before I arrive at the point of discussing this cycle in relation to my intentions, I would like to take a wider view of Rowan's ideas.

Rowan's reasoning about different research paradigms and how they relate to one another in their ability to either alienate, bring about social change, or develop a research cycle rang an accord with my concerns. Some of my ideas about alienation and social change still travelled with me, and I recognised that some of my own values were part of the Marxist philosophy I studied some time ago. These ideas about the alienation that workers feel when they do not have access to the products of their labour did not seem dissimilar to ideas about research subjects being alienated from the products of the research. As I understood it, Marx focused on the exploitation of the working class to provide profits for the owners of industry. It could be said that in traditional research, the research subject is being exploited by the researcher to provide him/her with a tangible asset - a published paper, a better paid job, status and authority, and so on.

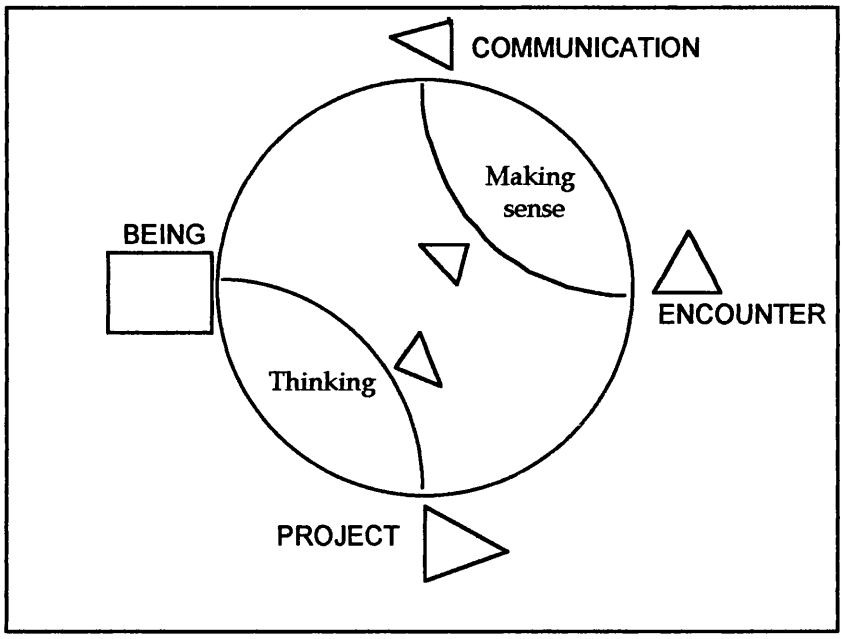
Rowan also refers to the alienating process of treating people as subjects rather than as full participants. He expands this idea of alienation to include four dimensions: work; the product

(outcome); the other people; and the self. He goes much further by stating that the researcher is also alienated within this paradigm because of the nature of the research and because the researcher shares the same research culture. I had difficulty in accepting this because I did not believe that the research subject was in any way of equal status to the researcher. I also did not think that being in the same 'research culture' necessarily brings about the same alienation for the researcher. If this were so then the factory owner would be just as alienated as the workers in Marx's analysis, and maybe they are in some complex way.

There was something about degrees of freedom of choice that can or cannot be exercised that was of interest to me and I did not think that this fitted with Rowan's analysis. It is possible that my perspective was more about being a woman in a workplace that is hierarchical and patriarchal, and also highly dependant on women's work. At this point I was reminded of the epistemology of critical theorists and I realised that my analysis exposed the values I held about the sense of powerlessness that nurses often feel in the workplace, and my desire to bring about change. However, given that I did not agree with all that Rowan argues, his cycle of research contained for me a sense of process, logic, and a certain flexibility around translation of theory into practice.

From my knowledge of Rowan's cycle of research and my experience of the 'nursing process', I found that there was an accord, a similar pattern, even though the actual events are different. Both evoke a cycle that is at once closed and progressive - closed in that the stages are repeated, and progressive in that the questions asked at the beginning of each cycle are built on the actions of the previous one. Each model passes through stages and although these stages are not identical, they have some concepts in common. Each begins with sharing information and formulating questions and possible answers. Each passes through stages of testing out and communicating the results of acting in the field, and each evaluates or makes sense of these experience. The nursing process passes through the stages of inquiring, planning, intervening, evaluating and reporting. The research cycle developed by Rowan commences at the point of thinking about the research activity and terminates with making sense of the information and experience arising from the actions taken.

The following diagram presents the complete cycle:



This diagram of Rowan's (1981) cyclical model (p. 98) represents the cycle of experience as the researcher moves from one stage to the next. Rowan's theme is that all research follows the same basic model, different research methods using the mode differently.

> "At one end of our continuum, this is seen as the standard alienated academic research project. —— At the other end of our continuum, is seen as a dialectical process of engaging with the world."

It was this dialectic end of the continuum that had compatibility with the research I intended to engage in. Rowan's cycle of research passes through the four stages of Being, project, encounter and communication, and although these stages are expressed linearly Rowan states that "--a dialectical cycle may often start with the moment of encounter"

From this dialectical perspective, the researcher first experiences 'being' in an abstract personal way where one is pre-occupied with some kind of internal disturbance. The desire to solve the issue, problem, or 'itch' causes the researcher to think purposefully and search outside the self for information. Once sufficient information is acquired, a plan can be devised to further inform the topic and this becomes the project stage. This leads directly into the encounter stage where the researcher gathers information to inform the inquiry. The researcher then works with this material to make sense of it in terms of the initial questions and the experiences that inform the questions. Through this process, communication becomes possible. There is a rhythm to this cycle as the researcher moves from internal dialogue, to dialogue with others of like mind, to searching for information, and back to internal dialogue and dialogue with like minded people. Finally the cycle moves to communication in a wider context, then back to being. Rowan takes the form of the cycle and applies it to different research methods thereby creating a different pathway. This flexibility allows the co-researchers to plan creatively and respond to the way the research path unfolds.

This shared central focus of understanding about the cyclical process of research seemed to provide for me the basis for a more rigorous approach to researching the practical and experiential

aspects of nursing. Rowan's point about research being several small cycles within a larger one allowed for more flexibility within the research, encouraging individual feedback, making sense, and communication as fieldwork progresses. I saw this as being an important way of coping with the various levels of participation, where shared understandings could be acknowledged and different realities encouraged. It provided for small cycles of research to be worked through during a group session, for individuals developing a small cycle of research in their own work place, and for contributing to a larger cycle of research. Similarly, cycles of research within the group could be part of a wider research cycle in the organisation, or parts of it.

Conclusion

In exploring the research cycle of Being, Project, Encounter and Making sense, I began to see some connections between Rowan's cycle of research and the way nursing relies heavily on the ability of nurses to really 'be with' another person. To be more effective in their role, nurses need to 'know' what they are noticing so that they can communicate this knowing to others. This is a challenge for nurses, and I include myself, because knowledge of the intuitive kind, gained from responding to needs of others without publishing the hows and the whys, is a part of nursing practice. This research cycle offered an appropriate process to find out 'what is nursing, and how do we help each other develop our nursing practice?' I added it to the ideas already collected, and saw it as process tool to manage the cycles of inquiry.

My thinking, reading and debating with colleagues, both at work and at university, brought me to the point where I was sure that the research I was planning would be qualitative research, and would involve some kind of group work with nursing peers. Having expanded and deepened some of my ideas in order to create a theoretical basis for the field work, I was left with the question, "What actually are the data going to be about?". I needed a method for actually doing the 'live' research that felt authentic and coherent with the way nurses work independently and together. I had always believed that how, and what, people learn influences their personal well-being. Consequently my own interactions at work often had an underlying teaching and learning source, and that influenced my choice of reading about how I would enter the field and do it.

Collaborative Inquiry

I was introduced to Torbert's ideas in my first term at Bath University. His very active way of approaching the subject of research caught my attention and I found his ideas about Collaborative Inquiry and Action Science both interesting and appropriate to the kind of work I was involved in. I now intend to present these ideas and how I saw their usefulness to my research.

Torbert (1981) states that:

> " The model of collaborative inquiry begins from the assumption that research and action, although analytically distinguishable, are inextricably intertwined in practice". (p. 145)

My own reflections at the time were:

> Practice for me has always been complex and unpredictable, and yet always there are strands of familiar actions and understandings that seem to transcend the presenting complexity and

confusion. The research journey relies on openness to the unknown, and at the same time alertness to the discordant and the unfamiliar. It is often through this attention to the actions of self and others, that inquiry develops.

Torbert states further:

"---the capacity of a social system to produce valid data becomes the degree to which confrontation and exploration of possible incongruities is initiated and welcomed." (p.150)

This gave rise to further reflections on my part:

The need to be consciously aware in any interactional process is one of the key skills in researching a social situation, if the outcome of that process is to be valid. The way in which this conscious awareness is to be learnt and evaluated is not so clear, although it is more likely to develop through acting in the world with others, willing and able to discuss their own perceptions and intentions, than it is through reading and discussing the hows, and whys, of it. Action in the world requires a self-consciousness that is able to monitor, and also provide a 'watching brief' without inhibiting spontaneity and timeliness.

In Torbert's Collaborative Inquiry, action and reflection are the key skills and need to be flexibly used in the context of: reflection in action; reflection for action; and reflection about action. These skills are best used in a context where the researcher and other persons invited to engage in collaborative inquiry develop an "increasing investment and subtlety of focus". This, Torbert claims, unless interrupted, goes through three stages of questioning whether:

1. the initiating actor-researcher and the system engaged will develop a shared model of reality in which a continued collaborative inquiry makes sense;
2. the participants are able to investigate gross incongruities amongst the qualities of their experiences - this requires a strategy for investigating;
3. the participants are able to obtain high quality results in terms of aesthetic appropriateness, political timeliness and analytical validity - this requires that the first two stages of engagement and investigation are effectively transacted.

These characteristics of Collaborative Inquiry seemed useful in the way they bound together the different ways of knowing described by Heron (1981) and Rowan (1981). They also linked with the way research can involve participants in a collaborative process which I have described above. The following statement from Torbert (1981) encapsulated the essential components of people working effectively together as colleagues or peers.

"--what practitioners really require is a kind of knowledge that they can apply to *their own behaviour* in the midst of ongoing events, in order to help them *inquire* more effectively about their common purposes, about how to produce outcomes congruent with such purposes, and about how to respond justly to interruptions." (p.140)

I saw this sense of seeking authenticity as an essential part of being effective as a person. The skills of reflection in action and reflection for action became for me necessary tools to develop for co-researchers and co-subjects.

Torbert (1981) discusses how a living inquiry can be developed that nurtures interpersonal competence and is:

> "not a matter of manipulating others successfully in order to achieve one's unexamined ends; it is rather a matter of creating a social climate of inquiry which aids in clarifying both personal and communal purposes and relationships as well as in accomplishing specific tasks". (p.140)

This statement brought together both the need to have rigor in the research design, sensitivity towards the participants and a climate that encourages self-disclosure, supportiveness and confrontation. I will pursue this concept of interpersonal competence in the next chapter where I present the resources I used to develop my understanding of being a co-researcher, co-subject, and group facilitator.

Developing an Appropriate Methodology.

Having covered the theoretical and experiential aspects of research I now needed to develop a structure that would in some way shape the course of the research and foster an appropriate climate. The question still unanswered was - 'How do I initiate and conduct the research field work, in a way that allows me to honour the insights that I have acquired through reading, thinking and debating, and also honour the resources that each member brings to the research process?'

Developing a research group

My research purpose was to set up a co-operative inquiry group with other nurses, to research how peer support and peer appraisal might increase our understanding and competence as a nurse.

I will now describe how the works of Reason (1988) helped to clarify my understanding of this way of managing a research inquiry. He states that:

> "At a minimum for a research strategy to claim the term co-operative inquiry, I would argue that the nature of the involvement of all participants should be openly negotiated, that each should contribute to the creative thinking that is part of the research and that relationships should aim to be authentic and collaborative." (p. 9)

Reason goes on to say that flexibility is implied in the statement and that co-operative inquiry can occur at different points in the cycle if that is the design of the research.

> "--the form of the co-operative inquiry can range from full collaboration through all the stages of inquiry, to genuine dialogue and consultation at the moments of project, encounter, and making sense." (p.9)

From Reason's discussions I have extracted the following key aspects of co-operative inquiry that need to be addressed if this method of inquiry is to be valid (I will discuss validity criteria in more detail in chapter four).

- participatory and holistic knowing- here the focus is on full participation and the ability to enter into the wholeness of the situation where "we seek a knowing-in-action which encompasses as much of our experience as possible" (p 10);
- critical subjectivity - this demands a quality of awareness that shifts from naive inquiry "based on our primitive subjective experience of the world" to a state of awareness where

the primary subjective experience is made consciously available as part of the inquiry process. It seeks to bridge the subjective and the objective;

- knowledge in action - this views knowledge as formed in and for action, "more often the knowledge that is really important –is the practical knowledge of new skills and abilities". Thus in co-operative inquiry, education and social action may become fully integrated with the research process.

Validity in this kind of inquiry demands that there is, within the group, a climate that encourages self-knowing, self-reflection and co-operative criticism. Reason presents a clear perspective on the kind of group that is needed to achieve co-operation, self-disclosure, and purposeful activities to meeting the research goals. When a group of people come together to address both group and research issues, this "demands intense commitment and subtle skills of those who would undertake it"(p.19).

It struck me that although it was clear that the initial enthusiasm would come from those who first expressed the 'need to know', in some ways it would also be a journey of discovery, an emerging process that would bring together the skills and knowledge of the participants, with the possibility of surprise as new learning occurs. My experience told me that this kind of group could not be entirely planned, it would be a purposeful activity that opens each member to experiences at all levels of consciousness, requiring a commitment to both the research purpose and the group itself.

In order to achieve this kind of commitment it was very clear that the research itself needed to have meaning for the potential group members, enabling their energy to flow into the research activity. In thinking my way through this potential problem I decided that I needed to pay attention to certain principles derived from my own experience and the readings. These principles are:

- setting up the group requires a phase of informing and negotiating with prospective group members to ensure that each member is clear about the purpose of the research and their role as co-researchers and co-subjects;
- some time needs to be spent with the group members agreeing the purpose(s) and ways of working together;
- this kind of research is a learning process therefore I need to be prepared to teach some of the skills about group work and research, and learn from others;
- the vitality of the group relies on the energy of the participants to contribute their ideas and experiences - a climate of openness facilitates this;
- status and power can alter the way interactions occur and should be openly discussed and negotiated before group members commit themselves to the project;
- whether a group is heterogeneous or homogeneous will have an effect on the dynamics;
- there needs to be several cycles of reflection and action planned early on in the life of the group to practice the skills and share experience;
- leadership in this kind of group is both facilitative and educative, the degree of each is dependent on the experience of the group members.

This clear identification of the principles enabled me to develop a design for the field work that paid attention to authenticity, the unfolding patterns and themes, and my own skills and experience in group work. Before I complete this chapter it is important that I summarise the purposes and methods that I thought would both liberate and constrain the field work. In the interest of clarity I will present it as I understood it at that time i.e.in the present tense..

Purposes and Methods

The purpose is to set up a co-operative inquiry group (Reason 1988) of senior nurses, interested in using an inquiry approach to understanding and enhancing their own practice and the practice of others. My role in this activity is two fold:

a. to facilitate the inquiry process so that the cycles of action and reflection produce the data that inform the co-researchers, about nursing practice and working as a peer group.
b. to provide an educational perspective within the group context so that the stages of group development compliment the research process.

The effective use of a co-operative inquiry approach is aimed at developing a healthy working group where group members can test out their understanding and experiences of practising nursing. It is intended that through multiple research cycles using the tools of action and reflection new constructs will emerge to inform nursing practice.

The methodology is based on a dialectic model (Rowan, 1981) in which research cycles are developed through the stages of being, project, encounter and communication. The relationship between ways of knowing- propositional, experiential and practical (Heron, 1981) are the basis for generating hypotheses, and testing these out experientially. Thus a shared sense of purpose is developed from which propositions will emerge as the group members gradually makes sense of their knowledge and experiences. The tools of action and reflection (Torbert, 1981) highlight the need to remain consciously aware of personal process in the midst of action. This is the skill that we, as co-researchers, will need to research effectively in the work situation and in the group setting.

Conclusions

Throughout this discussion of ideas and concepts, I have summarised the particular points about qualitative research that I intended to take with me into the field work. These ideas provided the touchstone for developing validity measures during the research process. I also took with me Heron's (1988) criteria for validity, taking seriously his statement that:

> "The coherence of the conclusions with the inquirers' experience is consummated through coherence in action."
>
> " New-found practical skills are applied concertedly in their research world."

I do not intend to explain these ideas about validity here because, as the fieldwork progressed, so I became more aware of the ways in which the work we did together might find validity. In presenting the first cycle of research in later chapters, I will describe how validity is questioned and pursued at the 'sense making/communication' stage.

This concludes the telling of my search, for a clarity of purpose and a methodology to achieve it. I am now at the point where I can appropriately present the research that developed within, and as a consequence of, the field work. However, before I do this I will provide a brief description of the fieldwork preparation. It is important to do this at this point because the process of engaging my nursing peers in the research process and the feedback I received influenced both the membership of the group the, and the kind of group I chose to develop. The process of participating in and managing the fieldwork was difficult, not only because we were all bringing our separate experiences to the group sessions, but also because I was expanding my experience and understanding of myself and the research process. This made it very difficult for me to 'stay with' members of the group and value their particular discoveries, difficulties and successes. The next chapter provides an outline of the research preparation and a glimpse of nursing through the voices of experienced nurses.

Chapter Four

Introduction

My aim in writing this chapter is to provide the reader with an understanding of the complexity of developing a coherent and working group in a context where research activities have focus and value. In beginning the process of setting up the group, I identified two major pathways to be negotiated, namely, the journey through the research cycle and the stages of group development. The first pathway is the touchstone for the emergence of themes and issues about gender, power, role conflict and the essence of nursing. The second provides a base for managing conflict, creating a climate of trust and risk taking, and for exploring more personal issues. In order to address both pathways simultaneously, four perspectives were used to:

- provide an overview of the group work both from a group development point of view and Rowan's cycles of research;
- move through the process keeping account of the development of research data and the management of the group task and process;
- return to the data to highlight and discuss the themes and issues that emerged;
- reflect on the particular issues and critical events that placed pressure on my role as facilitator and influenced the group process.

The skills of action and reflection (Torbert ,1981) as research tools were practised in the group and used in the work place to provided data and focus attention on particular experiences. Because nurses use these skills to manage the nursing process for patient care and the learning contracts for student nurses, I made an assumption that this way of working would be familiar, if not altogether comfortable.

In considering the issues that usually arise as groups developed and move through the various stages, I made a note of some that might prevent a group from moving forward. I decided to carry these concerns with me through the cycle of research and give myself a space at the end of each group session to reflect. My intention was to assess the degree to which I was able to facilitate:

- maintaining the balance between task and process;
- bring into shared consciousness the tools of action and reflection;
- manage the issues of conflict, leadership, gender, trust, power and boundaries;
- establish a pattern of working together that affirmed issues and themes.

I planned to work towards developing a cycle of activity within each group session and this session would become part of a the larger research cycle. My concern that nurses become more confident, more able to make public their intuitive thoughts and decisions, and more willing to experiment with their ideas and ways of working together, has been the catalyst for keeping in focus the role of experiential learning and intuitive knowledge in establishing patterns that might mirror the practice setting. Experience told me that recurring patterns, if

recognised, tend to progress towards a new level of understanding, particularly where nurses work together in a peer group using both reflection in action and reflection for action. The support and shared understandings enable individuals to feel more confident and able to act on their knowledge in the work situation.

Developing a framework for group and research processes.

In the context of managing both the development of the group and the research cycle concurrently, I considered the kinds of strategies that might be most useful and I made decisions based on literature, my past experiences, and the purpose of the fieldwork. From my past experiences as a facilitator I have found that, in groups where inquiry is the dominant mode, four main phases can be identified. Each of these phases are the subject matter of individual chapters and each chapter will conclude with my own observations and analysis.

The focus of each phase is as follows:

The first phase - sets the climate for working together through social activity and group sharing;

The second phase - aims to get agreement about the task and the mode of working together;

The third phase - takes up the challenge of achieving the task and meeting individual needs;

The final phase - provides a context for making sense of the total process so that a way forward is agreed and any consequential actions are taken.

Having clarified my beginning position and how I envisaged the group work would develop, I then considered the possible options for analysing group process and content. Although my experience of group work provides me with a range of different methods and philosophies, I decided not to analyse the group process using an established method. Rather, I decided to make a commitment to reflect on each group session and each cycle of research while bearing in mind the four phases and the expressed needs of the group members. I chose to do this for the following reasons:

- I wanted to be open to experiencing the group as unique;
- Working with both the research cycle and the group process required that I put aside models that framed too tightly;
- I wanted to establish a pattern and style of working that would encourage issues and themes about nurses and nursing to emerge without restraint.

As a consequence of thinking and reflecting, I conceptualised a structure for managing the group that was not rigid but provided a frame for experiences to occur and a way of working together to emerge. I will now outline the structure I developed and applied during the first research cycle. The terms I have used to identify the phases are graphic and have come out of the way I have learnt to manage groups, as well as from my own observations of different levels of activity at each phase. I have aligned each group phase with the corresponding (for me) research stage so that I am able to clarify my role and act in accordance with both agendas

'The Joining Phase' is the first phase and is about members of the group getting to know each other, checking out personal expectations and the expectations of others. It is also about clarifying the purpose of the group and testing out ideas and ways of being. In 'research cycle' terms (Rowan,1981), it is **'being'** moving into the **thinking** stage, because the over riding theme is thinking and puzzling about possibilities and ideas that can be tested in the 'real' world. It is also about joining ideas together to get agreement about activities that might be appropriate and acceptable within the group, as well as in the context of work.

'The working phase' is also about deepening the interactions within the group so that individuals are able to take risks about disclosing their own thoughts and feelings, and their experiences of nursing. This phase is about encountering ourselves, each other, and the world outside the group in a way that allows ideas to be tested, both in the group and in the work context. In research cycle terms it is the **project** stage where ideas are clarified and actions are planned to test out ideas and questions.

'The knowledge seeking phase' is about seeking out the issues that are important to meeting the requirements of the task. These issues maybe found within the group, an individual's personal life, or in the context of work. This has resonance with the **encounter** stage within the research cycle.

'The sense making phase' ,in terms of the group process, occurs when the group has completed the agreed task in content and process. The energy at this point is focused on identifying the ideas and experiences that are important to the group members, so that a shared understanding and sense of satisfaction is generated. In the case of this group, themes and issues emerged that reflected the experiences of nurses both in the work place and as we worked as a group. This phase in research terms is about **making sense** and **communicating.** Communicating in this first cycle was very much about communicating with each other and contemplating what nursing meant for us.

The final phase of meaning making requires careful timing so that it flows easily from the 'knowledge seeking' phase and allows enough time for summarising the content, personal reflections, and agreed intentions to act and reflect in the practise setting. Making sense of the research cycle, and the experiences that emerged, was more difficult because there was an unwillingness to 'label' nursing in terms of ourselves and our preferred ways of being. The group that formed the second cycle of research were willing to take this agenda forward. The members who decided to leave had either achieved their own particular goals, found the methodology too difficult to manage, or had other priorities.

My planned intention, from a research point of view, was to connect one group session to the next by identifying issues and agreeing activities, thus providing the feedback for the next session. In this way, progressive group sessions combined to complete a phase of the research cycle. I also anticipated that each group session would work through a small cycle of

research in terms of thinking, acting, reflecting and sharing points of view and understandings. The challenge I faced was to facilitate both the progress of each small research cycle and the ultimate goal of the complete research cycle concurrently, and to pay attention to the complete group process so that a coherent sense of a beginning, middle, and end is achieved. We developed a process of reflecting and giving feedback at the beginning and end of each session, providing a link between each session and a focus for identifying themes and issues. This provided a context for agreeing questions and ideas to test out in the field of encounter and bring back to the following session. This process both informed the larger cycle of research and strengthened the group process, particularly from a co-operative inquiry point of view.

Forming the Inquiry Group

In preparing for the field work I developed a tentative question to guide my actions. This question asked;

> "Can a group of experienced nurses meet together, share experiences, and inquire into each other's nursing practice in a way that enhances their work as nurses, and creates personal and professional knowledge?".

With this question in mind, I considered the factors involved in developing such a group and concluded that a support group, where nurturing, trust and honest constructive feedback are the key components, was most likely to achieve the purpose. These conclusions sprang from my own experiences of learning in a peer group setting where people are supported and valued so that challenges are accepted and conflicts resolved. To maximise the possibility of developing such a group, I considered membership, the size of the group, and what was required of the researcher/subject role. Having given this some thought, I decided that the participants needed to be experienced nurses, willing to participate fully in both the group work and the purposes and methods of the research - acknowledging that this would involve disclosing personal experiences.

To establish the research group, I called for volunteers by formally publishing my intentions and criteria. In doing this, I made it clear that the research group would be using a co-operative inquiry approach to investigating the nature of nursing practice. Interested senior nurses were invited to meet with me to discuss co-operative inquiry and my rationale for using this model. I wrote to all the Directors of Nursing services and schools of nursing within a particular district. I also sent cards to the local Department of Post-graduate Studies and to senior nurses who had participated in some of my previous workshops. From the responses to my invitations I set up and managed with the help David (husband, friend, colleague, and fellow researcher) a meeting with each group to explain the research methodology and to hear their responses to my research proposals.

To ensure that those attending were clear about what would be involved should they decide to participate in the research, each session included a formal presentation and open discussions.

After each meeting I recorded the issues and concerns that emerged and paid particular attention to the questions and comments that focused on the nature of peer support and appraisal. At the beginning of each group I presented my own purposes and the way in which a co-operative inquiry methodology might inform the case for peer support and appraisal, particularly for experienced nurses in responsible positions. I made it clear that my intention was to explore the value of peer support and peer appraisal in the working lives of experienced nurses. I also explained the way in which I expected the group to develop and the contribution that each co-researcher/co-subject would make. I used both overhead slides to inform the process, and made reference to both work and literature to focus the discussion. Each session produced a lively interaction and some of the concerns and ideas were repeated throughout the groups [and picked up again by the participants in the second cycle of research.]

The following statements are extracted from each these meetings and are individual responses to my presentation and explanation. The nurses were all experienced and came from the following settings:

- community and specialist nurses;
- senior sisters from a hospital setting;
- nurses working in post-basic education;
- nurses in mental health and learning disabilities.

For ease of reading I have grouped comments that seem to have a common theme.

Hierarchies, status and power in nursing

"I am not sure that I could talk about the things that really concern me if I thought someone was in the group that might be in a senior position to me."

Pressure of work and inability to deny others in favour of own needs

"I don't think that I could really change anything where I work, everyone is too busy to think about doing things differently."

"I would like to get together with other nurses and broaden my skills but there does not seem to be any time, and when there is I never seem to be working with the same person twice."

"I have tried to run a research group and very few people are able to attend because things crop up at work and nurses don't like to leave when patients or visitors need them."

Fear of showing feelings and becoming emotional

"I would welcome a group that had a facilitator, because the groups I have attended have encouraged people to talk about their difficulties, and then when the 'flood gates open', no one knows what to do."

"When you become a senior nurse you lose the companionship that you had. I think we need to support each other."

"Any group that could help me cope with the surgeons I work for would be worth their weight in gold."

"I don't think I could discuss personal issues because I would probably lose control."

Role conflict

"I really think what you are trying to do is important because nurses need to work together and get some acknowledgement for what they do- I would welcome a group that meets regularly to talk about some of the difficult situations."

"I think that senior nurses get left out of any support system. They seem to be viewed as either 'super women' or 'unfeeling monsters'."

"I would feel better about managing and perhaps trying out new ideas if I could talk over the difficulties with someone."

"I wonder sometimes if I am a nurse, I seem to be doing nothing but administrative tasks."

Managing groups and teams

"It's really interesting to hear your ideas about groups because I am aware that the nursing teams that I manage do not support each other very well at all, they all have their own workload and just get on with it."

"I am working to get my nurses working as a team but I am not sure that I am going about it the right way. Some are really great and some don't like it at all."

"I would be very willing to be part of a group that looks at improving practice, I find that being a senior nurse is a very isolated position- no power and very few friends."

All these remarks are familiar to me and reflect some of the issues that I was facing at that particular time. The themes of power, role conflict, and disclosing personal issues and feelings also gained voice as the first research cycle developed. After these first meetings I wrote to all those who had taken part and invited them to a second meeting where I would make clear the research commitments and the role of participants. Sixteen senior nurses declared their interest and attended the meeting. Of these sixteen, twelve volunteers made a full commitment the first research cycle and became the first fieldwork group.

This heterogeneous group consisting of three men and nine women: two were nurse managers of cottage hospitals; two were senior nurses managing a clinical areas; one was a senior tutor teaching undergraduate students; two were senior tutors developing clinical practice; one was an education advisor and team co-ordinator; two were clinical nurse specialists; one was a health visitor; and one was a clinical quality co-ordinator. We all agreed that the total life of the first research cycle would be no longer than nine months and would include an orientation session and eight group sessions, each session to last for two hours.

Beginning the group process and clarifying the boundaries.

At this first meeting we discussed how a research group might be developed, and the role of co-researcher/co-subject. I facilitated the discussion process so that agreement was reached

about the focus of the inquiry and the process of developing a working group. Individuals shared their expectations and why they had volunteered. We also agreed about when, where, and how often, the research group would meet, and processes we would use to develop the group process. We decided that the focus of our intent was broadly nurses and nursing, and to begin the process we would share reflections of practice situations. These reflections would provide the basis for formulating questions and ideas, and through this, our work and ourselves would become available.

As facilitator I agreed to co-ordinate and tape record the meetings so that each participant had a transcript of each session for reflective practice. We discussed how the facilitator role would function within a group of peers, and we all agreed to encourage an open inquiry process that respected honesty and the disclosure of concerns, worries, fears and successes. We acknowledged that we would need to pay attention to the group process and the roles we developed within the group setting. The issue of validity was raised and I provided a framework for reflection and discussion (Heron, 1988) as follows.

- Research Cycling involves the inquirers moving to and fro between reflection and experience so that each informs the other. This will be achieved within the group and the work context..
- The Balance of Divergence and Convergence reflects the content of the experience phase. Because nursing is the focus, divergence could become unmanageable, therefore action may be needed to pull together common issues and themes.
- The balance between reflection and experience is dependent upon the nature of the inquiry. Experience that is intense and contains complexity requires lengthy reflection, whereas straightforward interactions of a familiar nature may require little.
- Aspects of Reflection involves three major forms of thought:

  Descriptive - recounting phenomenological experience;

  Evaluative - seeking mutual coherence across experience;

  Practical - using previous reflections to plan future actions.
- Falsification involves the testing out of ideas against actual events, and noting incoherence and avoidance of disaffirming the idea or model.
- Chaos and Order is a balance that needs to be struck so that ideas are alive and research is coherent and goal oriented.
- Unaware projections occurs and needs to be managed when fear and defensiveness hinders and sometimes prevents honesty and risk taking.
- Sustaining authentic collaboration addresses the relationship between the initial researcher and the participants and between all participants. The role of facilitation, decision making and participation within the group are indicators of collaboration.

- Open and Closed Boundaries involves clarifying the nature of the research, and whether the research experiences are personal to the individual researchers or whether others are a vital part of the research and need to be 'heard'.
- Coherence in Action involves sharing ideas and finding coherence across the different contexts where action is taken.
- Variegated Replication refers to the ability of future researchers to use the reported inquiry as a starting point for developing their own constructs and field work designs.

We discussed the way in which we would manage these issues and decided that such roles as the 'devil's advocate'(the confrontation of collusion) should be explored. We agreed that time should be set aside at the beginning and end of each session to allow for personal reflections and inquiry. A decision about whether a second cycle of research should be anticipated was set aside until we had a better understanding about the fruitfulness of our intentions.

In preparation for the first group meeting I wrote to all the members to confirm what we had agreed at the introductory session, to thank them for their commitment, and to make clear that I would take responsibility for managing the first group session. Having completed this first step I spent some time clarifying my own ideas about my purpose for the research, and the kind of group I thought was needed to meet this purpose. I decided that clarity of purpose and being a nurse was an essential part of the research and a focus that held nurses and nursing at the centre would facilitate a shared purpose for action in the work setting. I intended to be open about this perspective at the first session by proposing that questions about nurses and nursing might be important to investigate first.

I considered the various types of groups that might be set up to meet different agendas and I decided that the most appropriate would be a 'self help' group that also provided challenge, analysis, and action oriented goals. I realised that although a self help group would provide a climate for peer support and risk taking, it might also reduce anxiety and limit challenge and innovativeness - a healthy tension between security and vulnerability seemed to be what was required.

Finally, before beginning the first phase of the group process, I selected a group process tool that would assist me to reflect and act in the group and reflect and plan at the end of each group session. Figure 1 is the tool I used and provides the rationale for the observations and interventions I made.

Self-Interaction-Task Observation Schedule

Pfeiffer and Jones (1977) Vol. 2 page 68

1. *Self-orientation.* What behaviours seem directed more toward individual members' needs rather than toward group aims? (dominating the discussion, cutting off others, horsing around, not listening, being overly aggressive, nit-picking, smoothing over arguments, avoiding responsibility.)		
Who did it?	What did s/he do?	What was the effect?
_____	_____	_____
2. *Interaction-Orientation.* What behaviours are aimed toward more effective group interaction?(keeping members involved, harmonising disagreements, reinforcing good contributions, relieving tension, encouraging co-operation)		
Who did it?	What did s/he do?	What was the effect?
_____	_____	_____
3. *Task-Orientation.* What behaviours are directed toward accomplishing the group's task?(getting things started, sharing information, organising, giving opinions, clarifying, summarising, checking out consensus)		
Who did it?	What did s/he do?	What was the effect?
_____	_____	_____

This completes Part One. In Parts Two and Three I will take the reader through the field work journey which will involve two cycles of research (Rowan,1981). The first cycle rigorously pursues my understanding of Co-operative Inquiry, and at the end of this first cycle the methodology is challenged. Although we re-affirmed our intentions to continue using Co-operative Inquiry, the way we work together changes and creates questions for me about 'making sense' from this beginning perspective.

Thus the second cycle begins with an overt commitment to cycles of action and reflection, and develops into a collaborative inquiry process where actions in the world of work become the focus for exploring experiences. In presenting Part Two, I will begin with an introduction that places the field work sequentially within the time-frame of this research. This is important because the field work is a springboard for exploring ideas, searching the literature, and investigating my own and others' personal experiences.

Part Two

Fieldwork as a 'Beginning Stance'.

I began this research degree intending to explore the usefulness of peer support and appraisal within a peer group setting. During the first year I pursued this intention vigorously and in 1991, six months after enrolment, I began the field work. The way this journey unfolded reflects the activities and experiences contained within the peer and colleague relationships we developed. It is important that this sequence of events is understood by the reader, because my own life strategy and the sense I made of these experiences are reflected in the way I managed this process.

The field work is essentially contained within the two research cycles, and members of each inquiry group, including myself, provided the data that has informed this narrative. These two inquiry groups were a part of my working and personal life for two years, and continued to influence my thinking and acting as I made sense of the data and developed this research account.

The Purpose of the Fieldwork

I began this field work with the original question in mind:

> "Can a group of experienced nurses, meet together, share experiences and inquire into each others nursing practice in a way that enhances their work as nurses ,and creates personal and professional knowledge?"(p. 94)

The field work in Part Two initiated the 'living data' that I and my colleagues produced as we worked together within a Co-operative Inquiry modality. The first research cycle is contained in chapters five through to eight and the second cycle in chapter nine. However I revisit the second cycle of research in Part three and give a different account of both the experiences we shared and the way we worked together. This 'other' perspective is informed by my understanding of story as a representation of personal experience, and the relationship between life strategy and acting in the world. The sense I made of my own research experiences from this time arise from this change of perspective.

An Overview of the First Research Cycle

Structures and processes and presentation.

My role in this first research cycle was fourfold:

- to introduce and support the use of the research method and tools;
- to facilitate a group process that encouraged risk taking;
- to manage the information generated by the group;
- to share my own experiences as an equal participant.

The first three chapters(5-7) focus on particular phases of the group and the research development, and provide information within the following parameters:

- my own observations and rationale for decision-making as facilitator;

- the dialogue that focused group energy and contained recurring issues;
- an overview of the progress made at each phase of group development;
- identification of the issues and themes that emerged.

Dialogue is included that identifies issues, themes and emerging patterns. My comments and analysis are base on my understanding of groups, and on my efforts to monitor and manage the research process

Chapter Eight is not consistent with these first three chapters because 'sense making' and agreeing a second research cycle required a different process, one that encouraged closure of the first group and agreements about the nature of the second group. I will now present a brief over view of this first research cycle.

The Research Cycles

We began the **First Research Cycle** by agreeing to use the process of reflection in action and reflection for action (Torbert 1981) as ways of attending to, and managing interventions. Reflective diaries were used to record and interpret these experiences. Story telling emerged as a way of presenting personal experiences within the group setting, however I did not focus on this information as 'story' until the second cycle of research.

We agreed to use a tape recorder, to record the group sessions and for the first three sessions I transcribed the tapes and sent a copy to each group member. As the transcripts were difficult to make sense of we decided that copying the tapes was the best way of sharing the information and I agreed to send a taped copy to each member after each group session. The ethical and personal issues about taping group conversations became a key concern later in the research.

I personally managed the taped information by scanning the tapes after each group session and used the group analysis tool (Pfieffer and Jones 1977) to review the group process and extract the significant dialogue. The extracted dialogue was deemed significant either because it lead into some group action or conclusion, or because the group reflections at the beginning and/or ending of each sessions affirmed its importance. At the end of each group phase I summarised my own reflections and sent these to each group member for comment at the next group session.

As the group work continued so I developed the data, and at the end of the first cycle of research the content of the tapes and my own reflections provided the basis for assembling the key themes and issues. These issues and themes became the focus for making sense of what we had encountered, for resolving differences, and for agreeing the themes and issues to take forward into the second cycle of research. For some members this meant disengaging from the inquiry group and for others planning the second research cycle. During the course of the first research cycle my own personal research through reading, being part of the Bath research group and researching my own practice, contributed to my thinking and doing.

During the **Second Research Cycle** I began to question some of the decisions I had made about the research process and as a consequence felt pressured to revisit my rationale for setting up a group process. My growing sense of nursing as a gendered occupation became powerfully present as I worked through the sense making stage of the research. This caused me to revisit and reinterpret the conflict that emerged in the first cycle. My understanding of power and gender influenced the way I managed and contributed to the second research cycle and although stories were used to share experience, I did not consider story telling as methodology until I tried to make sense of the data I had collected. Consequently the second research cycle reflects a different way of working and a different way of making sense although it followed sequentially from the first cycle.

In the second cycle of research the group work is much more free flowing with most of the date generated by each member through encountering personal experiences in the workplace. The Co-operative Inquiry modality (Reason 1988) is applied by each member as they pursue their own research intentions within their work contexts The group becomes a focus for sharing and inquiring into experiences. Consequently the facilitation role is shared and I take an equal role in presenting my own experiences and supporting the work of others. Work within the group becomes more of, 'an event' in the research cycle as work in the practice setting becomes more central. Here stories and accounts of fieldwork activity provide the basis for reaching into our personal and professional lives. Together we search for the identity that is nursing, and consider what that means for us as a group. My own personal cycles of research are part of this search and provide a link between the field work and other parts of this thesis.

The process of **making sense** of the field work is in two parts chapters eight and nine. The first research cycle is more straight forward because we shared the data that was gathered at each group session. Therefore, I used the transcripts, the conclusions and ideas generated during the 'sense making' phase, and my own reflections, to construct an account. Each draft account was sent to group members and we met on three occasions to discuss and negotiate. As a result of these discussions what seemed irrelevant was omitted and what seemed ambiguous or too transparent was rewritten. In doing this we agreed certain parameters - real names would not be used and conversations would not be transcribed in full.

Presenting an authentic picture of what we did, and how we did it, was difficult and involved several drafts with contributions from group members. Once I had some consensus about the issues and themes that represented the way we worked together, I then extracted dialogue that seemed to surface a particular issue. Using this dialogue as the focus I used my own reflections and the research methodology to comment and make sense of the group and research process. The 'drafts' that were developed in collaboration with group members provided a fuller account of our work together than the actual research account I have written.

The final version of this first research cycle is a very small part of the original work because the fieldwork, once a centre piece, is now a platform from which my own personal research has

emerged. Much of the detail, and maybe the richness, has been modified because the research journey developed a life of its own and required that I pay attention to my own discoveries. The final writing has been achieved with the reader in mind and aims to honour the group work, my own research journey, and the need to present the complete document in a coherent way.

My approach to presenting the second research cycle is more complex because I begin by attempting to use the tools of Co-operative Inquiry to generate a research analysis of the data gathered and very soon realised it was unsatisfactory. We certainly began with the focus of our attention on -"What are we facing in our own particular work places that challenges our beliefs about being a nurse?" and - "What could we as a group contribute to the decision making achievements and conflict resolution for each member?" However, having agreed this focus, 'encounters' in the work place became personal events with each individual planning their actions and bringing to the group their personal reflections in and about action. This was because we moved away from cycles of reflection and action agreed within the group, to individual's paying attention to experiences in action and sharing these experiences with members of the group. Consequently the data collected was about individual experiences and personal reflections and ideas.

However, I used the data available to write a first account of this second cycle of research. In doing this I was able to explore the way we developed the group process together and the research intentions each person pursued. This first account is contained in chapter nine together with my analysis of why it became so difficult to write and how I found a way through this impasse. Therefore chapter nine will also prepare the reader for a re-interpretation of the second research cycle.

Chapter Five

Introduction

This chapter presents the first phase of group work and with in this the 'thinking' focus of research for each co-researcher/co-subject. The main components of this chapter are:

- The dialogue which highlights common issues and group decisions;
- My reflections and comments during the group sessions
- My reflection and analysis about the research progress and group development.

The Joining Phase

This phase includes two group sessions of each of two hours. The first session seeks to clarifying the research purpose and foster some sense of group cohesion. The second session opens up ideas and experiences about nursing and being a nurse, and establishes a way of working as a group. My central concern was to raise the activity level so that both task and process were addressed with energy. As facilitator, my intention was to be alert to the contributions each person made and the degree to which members were able to resonate with the research methodology. My aim was to give information and a sense of direction without being too directive This involved keeping an interactional orientation and an alertness to opportunities that allowed clarification of the task. At the end of each group session I employed the Interactional Tool (Pfeiffer and Jones 1977) to review the group process. The group members made a commitment to recording their own research activities between each group session. It was clear to me then that we were keen to encounter the world of work, and to test out the issues that concerned us. Paying attention to 'critical incidents' [issues that gained attention because of the possibility of negative outcomes if an appropriate response is not made] and using action and reflection to notice personal interactions and decision making, became the stated intention as the joining phase developed and ideas were tested out for significance.

The two groups were held in a comfortable venue with refreshments available. The first ten minutes were taken up with social interactions about work, home, and world events. I moved the group into the group process as the initial energy level subsided and attention became focused on beginning the group process. We began with each member providing a statement about their concerns and expectations for the first session, and I framed the introductory question in terms of feeling comfortable together, and having some clarity of purpose. I re-affirmed that being a nurse and nursing was central to the research purpose and individual experiences the source of information. The following tasks emerged from this introductory information sharing:

- to clarify the research purpose and methodology;
- to share the ideas about workplace activities between the group sessions.

I welcomed this clarity and presented once again the research purpose and methodology and then encouraged a discussion. The key points presented and discussed were:

- It is a personal journey, it brings about change, it has cycles of reflection and action and a research cycle of thinking, project, encounter, and sense making;
- This kind of research leans on ways of knowing that resonate with the nursing process and peer appraisal;
- It is important to adapt the research tools to suit the way each person works;
- Nothing that we do should be excluded because we think it 'might not be nursing' being open to noticing experiences is the key to locating the data.

Developing a 'life' as a group gained attention at the beginning of the group work, and the co-subject role in the work place was questioned and debated. A sense of stability gradually emerged and this set the scene for the dialogue to focus on testing out personal experiences of being a nurse. The following dialogue illustrates the key issues that arose, beginning with a discussion about the use of the research tools, then opening up into issues of:

- Developing the life of the group;
- Power and powerlessness;
- The meaning of nursing for nurses;
- Critical incidents in the lives of nurses.

I have not identified individuals within the dialogue unless they present a significant issue that requires 'tracking'. This is because the data selected represents ideas that gained focus for a considerable time, or were visited on several occasions. At times I have linked issues together to provide an ease of reading. I do not believe this has altered the sense of the dialogue as originally spoken.

My voice is in *italics* the group members [GM]in - body text and my comments and ideas at the time are in [text]. **If the voice of a particular group member is identified a pseudonym is used**

DIALOGUE

Using the Research Tools

GM-What I really imagined was that we would do what we normally do, but be more attentive, paying more attention, so that you can describe it more freshly.

GM-But being more attentive to it, does not necessarily mean that you will do things the way you normally do, does it?

This opens up general discussion about what it meant to pay attention to one's own actions in the midst of action. There was a general enthusiasm to try it out. However, I was concerned that people should not be restricted at this point and that divergence was important. I was physically and emotionally cued in to watch for any closure and it came

GM-You said that we as a group would agree on a topic or something to look at. Is that what we are going to do? Decide on something like dealing with relatives, or some activity and then concentrate on that?

The research model does not require a single choice of focus, we don't have to do everything the same. We just have to agree about the next step of taking the research ideas into our work place, and then making a decision about what activity each of us will pay attention to.

GM-So as a group we could decide to do different things?

Yes, but it should be part of your work because it is about reflection in action, so we need to teach ourselves to reflect while we are acting, as well as reflecting afterwards and before.

GM - And if we went out there and found it difficult, could we then bring it back to the group and talk about it?

GM - Yes we need to pay attention to what happens to us as individuals and as a group. What happens between us is as important as what happens to us at work.

The conversation involved a few more people before changing focus. My intention was to link the research in the work place with the work in the group so that eventually a flow of information and activity would develop between the group and the work context.

I felt that this piece of interaction had helped to clarify the action and reflection that was needed to produce the data, and to give us a group focus for talking about our work, and the contexts in which this work takes place.

Developing the 'Life' of the group

We then went on to discuss the way we would work together as a group. Members were testing out possible ways of relating to each other and what might, or might not be acceptable within the group context. At this point conversation flowed quite easily. However, conflict arose for the first time and is important to record because it exposes the group process, issues within nursing, and the validity of this kind of research.

It began with the question about the sense of togetherness in groups and how that can be achieved. One of the group members had commented on feeling more relaxed and together as a group. Thus the next statement cut across the open supportiveness that had begun to develop.

GM-It might look like we're together but deep down there is an amazing, well not divisions, but people aren't really together.

I noticed at this point the focus of this statement was not the group but personal experience, it seemed to be about not trusting the appearance of trust or the word trust.

---It is a fact that we find it very difficult being in a group, we can't actually keep up.

This seems personal and is 'short hand' for some feeling state.

---I think that whatever meeting I go to in my life there are stages that I cannot keep up, my attention comes backwards and forwards and in and out of it. That sense of togetherness is actually fairly unique and doesn't happen that often. It's nice to think that it does and that we make some consensus decisions. I would suggest that the majority say that is a good idea [the topic] because they are with it, but there are other people who will go away and say "I wasn't really agreeing with any of that", and it's this sense of- "Is there any togetherness in our lives or how do we get this togetherness together?.

There were several levels of communication going on at the same time in this statement. I observed members showing differing non-verbal responses all with some degree of withdrawal. I noted that this 'cutting across' the simple statement of 'being a group' with a really complex set of ideas, felt like a challenge. Maybe it was aimed at my leadership, or the sincerity of the people in the room, or something else. I chose not to inquire. As I simultaneously tracked my own thinking and paid attention to the group, I noticed the tension rise and the energy ebbed as eyes were lowered and people moved back in their seats. I let some silence pass and then I responded,

My first response to you is that those sorts of questions are part of the ways in which we need to validate some of the ideas that we generate. ----The other side of your question is about how much we are a group here, and how much we are individuals?

I then follow with a short statement about my understanding of what we bring to groups and who we are in different groups. I wanted to open up the opportunity for a discussion about work groups. This opened the way for others to participate

GM-I think groups come much more together as they work together. When we are apart we are not a group, and when we are here we are not necessarily together. But if we go on working together, and if we develop more empathy, then the group will be more together.

Some more comments were made about personal understandings about groups and group work and then the initiator of the challenge to group cohesiveness brought another dilemma into the group.

GM- Quite often teams are reaching the wrong sorts of goals i.e. we're actually together because we're very good at generating conflict amongst ourselves, but that's not the intention of a group working together. If we know what we are expected to be doing as a group we're much more likely to do it. What you [referring to me] are saying is that maybe it is the process we need to look at, but for me if we know what we actually are supposed to do, we feel much more confident about it because we are more likely to succeed.

I noted that conflict, goals, success and clear outcome measures, were surfaced in this statement, a preference for tasks. I did not need to respond as there was no silence this time.

GM- But is it not a good idea for us to identify what we're going to do and how we're going to do it? Both are important to me.

Without making or allowing further comment the original speaker went back to his concern about togetherness

GM- All of us deep down have this fear and panic about togetherness. One of the essential reasons why we panic about it is because we're not quite sure what the goal is.

I noted my own tension rising and a clear sense that I was being challenged about the priorities between task and process, Another member took up the challenge.

GM - I personally do not agree with you Neil because I don't feel panicky at all, intrigued because it's unique and it's never been done before, I've never done it. It's a process we can go through where we can all learn. Panic does not really come into it. A feeling of doubt perhaps about my own ability to do what is required of me, but then we can decide as a group what is comfortable for each other.

Others took the initiative and I had time to consider my position on what had been said, keeping in mind that this was the first group and my role was to ensure that all the members felt heard and engaged. I did not intend to test out too directly at this point. Finally the interaction slowed and I decided to use the opportunity to affirm divergence.

I think this is a healthy challenge to us as a group and I would like to tell you what I am thinking. I am pondering whether we create a group that can achieve what we are all wanting to achieve. That is becoming researchers and learning about ourselves and our work in a very positive way, and affirming and maintaining our differences?

A lively discussion began about the importance of being different without feeling outside the group. One member commented on feeling outside the group because several members in the room had worked together, and three members still did. We then discussed how we would test out our own ideas about what we did as nurses using an action and reflection model.

Power and Powerlessness

The next dialogue occurred during second session. The first extract is a centred around the issue of working with other disciplines, particularly doctors.

GM-I think one of the things I agreed to do was to reflect on the issues that arise when I try to negotiate with members of other disciplines.

This is a nurse manager negotiating with general practitioners.

----I think the only interpersonal skill I had to adopt was not to say too much. I had to stop myself leading into any discussion that may lead on to argument.

This led to an inquiry about what was meant by "an argument" and why it needed to be avoided, Other members shared their difficulties in working with general practitioners

particularly when it involved allocating nursing resources. It was agreed that the use of power was a concern in this relationship.

A natural pause occurred and a group member picked up the theme. I noticed that it was easier to allow silences because members of the group seemed to be more comfortable with picking up the issue, or introduce a new one.

The next dialogue was more about powerlessness and the feelings and emotions attached to being vulnerable and not 'in charge' of ones own future. Or unable to relieve the discomfort of others.

GM -I thought I would like to concentrate on an interaction that causes difficulty--

A pregnant pause - the speaker is a senior tutor that has been through a very traumatic time of watching the nursing school diminish with no real personal future security.

- - -I was going home yesterday and I realised that the experiences I have had in the department have been very powerful and very painful.

This was the first time that a group member had introduced personal pain and nurses not being able to take care of each other.

The speaker was encouraged to talk about the changes that had occurred, and the insecurity and conflicts that arose as jobs were redefined, and people who had worked in teams together had to compete with each other. The issue of change, and nurses being powerless to manage this in a positive and proactive way was affirmed. Others members produced examples of situations that held the same sense of being at the mercy of another's will. However one member presented a story about changes that seemed to be more proactive

GM-Since the last time we met I have had one or two experiences that have made me aware that I am actually handling situations in a totally reverse way from the way I was handling them, say five or even two years ago. I tend to confront where I used to be more tentative, and be more subtle where I use to be aggressive.

This begins a story about managing teams in the community and brings to the surface issues about developing interpersonal skills that encourage positive relationships. An open discussion about the changes in styles of work that occur when nurses move to a management position, follows this story. People who have management responsibilities share their ideas about facilitating the work of other nurses and being accountable for the management of a service. This open discussion involves some of the more silent members.

The next speaker had said very little until this point. However she contributed with energy and enthusiasm as she talked about the hospital services she was responsible for.

GM-I like to try and discuss with people and change attitudes by agreement, but I was so fed up the other day with a situation where the client was suffering physically. In the end I told the staff that this was the way it had to be done, and felt very uncomfortable afterwards.

GM-That's interesting because in a completely different setting there is someone who has actually insisted that I do something, and that has put me in a very difficult position because I do not think that she has the authority to tell me what to do.

This is a community hospital manager who is in conflict with the new District Manager, about how the serviced should be managed. I realise that all these issues are about power or powerlessness and are played out in very close ongoing relationships.

GM-But relationships are both ways aren't they, because you neither want to be telling or be told what to do. Particularly when it affects clients and colleagues.

The conversation continues to circle around power and powerlessness with out actually naming it.

GM-It's funny this conversation has taken me back to when I was a charge nurse doing student reports----I really hated denying the student the right to move on and it was a real struggle because I did not want to use the authority I was meant to have.

This statement seems to connect with the kind of 'unfair' authority that is being used to decide the future of teachers like herself. I chose not to raise the relationship but follow the theme as it emerged - authority that gives power to harm another is not welcome.

GM- For me the issue is about knowing the criteria for judging somebody and being sure that the student understands isn't it?.

This is logic but does not acknowledge the context in which authority and power is located.

GM -That's the logic of it, but it is the intuitive side, the feeling side that gets in the way.

What do you mean?

GM-Well you knew that you were going to upset the person, and that you could destroy their future. The problem is, although you have the criteria you can never be really sure. There is always that doubt about the whether the decision is justified.

GM -One of the things that is thrown at nurses is that nurses do not want to be out of favour and that is why they do not make important decisions. I think it is about whether you can be sure that this person is not capable.

GM -But I think it is about wanting people to succeed and wanting people to do well.

GM -Well it is interesting because it raises for me the whole question of ownership of power.

This is the same person who challenged group cohesion and he is now 'naming' power.

GM - ----You may be exercising authority there, but you may not feel that you are fully involved, and really have the power to shape the situation so that it is satisfactory to you. So really you may have felt more able to exercise that authority if you had been part of the process from the very beginning. The question that comes to my mind is, On whose behalf are you acting, and do you truly take ownership of what you are doing?

There is silence and I test to see if the concept could be taken further.

-Yes a lot of it is actually acting under other people's power. A considerable amount of the nurse's power is delegated power from the doctor or administrators.

This is a new dimension and I notice the energy flowing more freely as people engage around the issues of power and powerlessness

GM -Yes a lot of what I do is not from a position of power, it is personal power or power from others.

This person is owning their use of power however the challenge is not taken up but a connection is made with a familiar ideas about nurses and nursing.

GM -I certainly think that nurses are socialised into behaving passively. It is quite clear to me that this is a trait that grows as time goes by. People entering nursing do not start out passively. I do not think they are picked because they are passive, but I think it is something that grows.

This is the member who began the discourse on power by discussing the changes in the school of nursing. The field of focus has widened to include the wider context of the organisation and the role of nurses in maintaining the institutional culture. Is this a more liberating analysis? I asked myself at that time.

GM - It is not really that people have power over you, it is just that their power encroaches.

GM - But that is still power over because if they can wield power that stops you doing what you need to do, then it is power over isn't it?

This interaction only involves a few members, and while I am pondering over whether I should try to slow the pace down, and bring in one of the quieter members of the group, another member interjects.

GM - Ann we rode over your comment what was it you were trying to say?

GM -It was the thing about people being passive and passive people being nurses. I was thinking about the use of power, and how personalities use power, and how people respond to situations where they feel dis-empowered. Like having to follow instructions and not interpreting those instructions whether they agree or not. It seems to me that nurses don't necessarily follow through instructions in the way that they were written. They put their own interpretation on it in order to exercise their own power and authority.

But it is not overt is it? In some ways whether we are passive or pacified we do not usually address the situation directly.

My intention is to test whether members feel they have any real choice about how they cope with situations that are power related.

GM -No being active and authoritarian isn't a useful trait for nurses. If you are powerful with your patients you end up with a passive unhappy and more ill patient, so maybe non authoritarian nurses are better for patients.

I notice the shift in focus to the nurse patient relationship and how that, in some way, determines how nurses manage their own power. I decide to shift the focus from power per se and test out another frame.

Doesn't it go beyond individuals? Isn't it about being given the responsibility to do things but not the authority to do it well?

GM - So it is not just about personalities and personal issues, it is about the structures that we work in?

GM - Yes, I think so. I was just toying with the notion that it is powerful to be passive, but voluntarily facilitative. You have to be very confident to sit back and allow other people to be what they want to be, and to feel that you can live with the consequences of that. I know when I am most offensive and active is when I am feeling most vulnerable, and least competent. I react aggressively to hide it.

The focus on the organisation as the context for feeling powerless seems to have provided a space for sharing vulnerability and ways of coping with interpersonal stress. There is an acknowledgement that nurses behave in ways that give inaccurate messages.

This led into a discussion about how much we express our feelings honestly and in what settings it is possible. There were some comments about needing groups of friends and colleagues to be able to 'let go' with, and some comments about not being able to trust people with ones weaknesses.

The focus then moved to the difficulties in managing nursing in a climate of continuous change. The dialogue was between three members and I noticed that other members seemed to be passively listening. I decided to invite one of the listening members to talk about her position because she had just given up a management post. I was also aware that illness was a significant factor in the job change.

The meaning of nursing for nurses

Julie, you have been in that situation in the past and you chose to leave . Is it very different for you now?

GM -I am very isolated at work, it is a new job and I am working away on my own. I always thought that nursing was working with people on the ward, but in this job I could actually lock myself away and no one would notice. I did not think nursing was ever going to be like that for me.

Julie goes on to tell a short story containing many of the anxieties that GM's have covertly expressed about moving away from 'hands on' care.

GM - I was having a conversation with one of the business Managers the other day and explaining to him that I was a Clinical Practice Development nurse. He said, "Oh are you a nurse?" I took a breath before I answered, and then I felt I had to justify myself. Afterwards I thought "Why am I doing this? Am I really a nurse?" I always thought of nursing as 'hands on' care for people who were sick.

I had taken a risk inviting someone to talk and I was re-assured when it opened up an important issue that was shared by others. The remark caused a great discussion about what nursing really was. Ideas ranged from 'hands on care' to a wide range of things that nurses do. When the interaction had widened and then centred around the core ideas of, 'activities that promote, facilitate or provide the care that people need to move towards health' I sought some closure.

It seems that we could discuss for a long time and not really feel completely satisfied. Perhaps we should keep our minds open to accepting that nursing is what nurses do. Then, when we have brought together enough information we may be able to find some common threads in all our various activities and roles.

After some more discussion it was agreed that to keep the concept of nursing open would be more in keeping with a research perspective. The focus then moved to presenting critical incidents from our personal records and rememberings.

Critical Incidents

GM -I have got two situations I would like to illustrate. I can't really call them critical incidents because they keep on recurring. Although I do have strong feelings when they occur. It is about wanting to collaborating with patients and families and other team members, and working with clients where my power and authority seems to act against the client wishes This is because the client is wanting to do something illegal.

This statement created a very lively discussion about how much we tended to respond to demand and how much we made judgements about need. It also brought out the difficulty nurses feel when they have power that is delegated by doctors and is therefore dependent on medical decisions and judgements.

GM -That is very similar to my dilemma. I want to work alongside people and make decisions collectively, and collaboratively, but I do not want to get into power games.

The discussion then moved to issues about managing people. The previous speaker then presented his second critical incident which was about being able to delegate to less skilled team members.

GM - I really want to work with people in a team, so I set up these meetings in the morning with my little team to discuss nursing care planning. I thought that the nurses would come up with the problems that patients have, and then we would all bring in our ideas and find solutions. It wasn't at all like that. I didn't realise how complicated these clients are (drug addicts) and how inexperienced the nurses were. I ended up by telling them what to do and that did not feel very good at all.

GM - That happened to me too. But my situation was a bit different because I did not have the time to explain and help the nurses through some of the possible difficulties. It always leaves me feeling 'run off my feet' and guilty because I have not been really helpful.

GM - I just feel a bit hopeless about it all. There is a real sense of being responsible but also knowing you can't do every thing.

This focus held attention for some considerable time. The conflict between being responsible and wanting others to be competent was echoed across the group. There was a real sense of not knowing the best way to encourage competence in more inexperienced nurses because it can't be 'told' in straightforward ways.

Interpretations and Reflections

My interpretations and reflections are centred on my role as a facilitator of both the group development and the unfolding of the research process. Of necessity I will also reflect on my own experiences and the decisions I made for action and in action during the group process. To make a circular and interwoven process simpler to understand I will present this section under four headings:

- The group development
- The research process
- My personal responses and actions
- Issues that need to be held aside for further information

I would like to begin with group development because it caught most of my energy during the group sessions. It is also important to the research process, because this methodology relies on members of the group being able to share ideas, and work together in an authentic way.

The group development

My thoughts and interventions at the beginning of this phase were more interaction oriented than task oriented. I encouraged the group members to voice there ideas and concerns before making an intervention myself. I did not allow tension to continue very long before

using an intervention that would have a good chance of increasing cohesion. I observed an emerging pattern of changing focus and energy as the group moved through engagement, focused activity, and disengagement. At the conclusion of each session group members reflected on their own experiences. We did not question each other about our contributions to the group task or process. In the second group session further risks were taken by some members in presenting interactions that had the potential for conflict and/or strong feelings. I was aware of the risk, but I did not comment openly because there was acceptance and sufficient support to keep the interaction flowing between more than two members. Once these interactions faded I tended to be active in encouraging new topics, or making connections between one topic and another.

Non verbal communication was more actively used and received and subgroups emerged, providing affirmation and support. I considered that the group had established a way of working that encouraged an exploration of ideas and self exposure. However, because some members remained silent for the central part of the group, I raised my concerns during the final feedback session. I asked the group as a whole what being 'non-verbal' meant as a way of communicating. The 'silent' members were able to state their positions quite confidently e.g.

GM - Sometimes I have something I would like to say and someone else says it. Then I sit back and listen to the conversation.

GM - It is encouraging to hear some one say the things I have been thinking.

GM - I need some time to work out what my ideas are and what are some one else's.

GM - I do not know people very well. I need to wait until I feel I know where people are in relation to me.

There was some discussion during this feedback. This led to an acceptance that people made choices about actively participating or not.

The research process

The research focus for the first group was to engage in 'thinking' about what we do as nurses, and what we need from each other to explore our nursing practice. We agreed that much of this thinking arose out of 'being' and experiencing our own feelings, ideas and energies. My role was to encourage ideas to be expressed, questions to be asked, and information to flow. The first session set the scene for thinking about the research and the ideas and practical possibilities that might be appropriate to pursue. I used opportunities to link ideas about research with actually clinical activities. The skills of reflection in action and for action were discussed and practised, and there was a high degree of energy around seeking out the issues important to nurses and nursing. I found, on reflection, that these issues ranged from actual experiences of conflict, to looking at the influence that the organisation might have on nursing. I found the level of thinking and discussing deepened as possibilities were generated that complimented 'beginning' ideas.

I started to create a bridge between the group process, and the research development, by probing and testing out ideas that related to activity within the group and the work place. It appeared to me that issues were emerging that gave nurses choices about their role and the way they might address some of the incongruities within it. These choices held within them potential for conflict and anxiety. Not being clear about what one actually does, and needing to be seen to act responsibly, has advantages as well as disadvantages.

My personal responses and actions

Four issues gained importance during this first stage of the research cycle. They were:

- a stated commitment by members to working on the research project;
- ways of working and interacting that maybe gendered;
- managing the research boundaries within a group context;
- challenges to the group cohesion and leadership.

These issues deserve some comment because they provided a marker for taking both the group and the research forward. Very briefly I will present my personal responses and actions in relationship to each,

Stated commitment by members to work on the research project

At the beginning of the first group meeting I was anxious about whether members of the group were participating out of loyalty to me, or because they were genuinely interested in this way of researching. I felt a sense of relief when members demonstrate a keen interest in the principles of the research and stated their enthusiasm about being a member of the group for their own sake. I have reflected about this sense of obligation versus seeking experience and knowledge. Although I know that some of my colleagues are concerned to support me in the things I do, in retrospect I am convinced that this reciprocal support is part of being a nurse. Being able to rely on other nurses for support is part of belonging to a wider community of people who understand the issues of one's working life.

Ways of working that maybe gendered

Three different aspects of group interaction contained a sense of genderedness for me. The first was a questioning about group cohesion. This arose when a quieter member of the group mentioned that they felt a sense of belonging in the group. The challenge was by one of the men in the group who presented a doubting stance. His intervention could be seen as a useful test of the group and the research process. However, it silenced verbal interaction between members and raised the non verbal. there was no direct response to either the content, or the possible messages within the challenge. The second was the a challenge to my bid to pay attention to the group process in order to provide a climate of trust and risk-taking. Again the member concerned presented an alternative agenda, one that emphasised task and goal. The rationale seemed to be the need to know, absolutely clearly, what is to be achieve in order to be successful. Group members responded to this bid for certainty by using

interactions aimed at harmony and cohesion. The third issue was about the use of power. This issue was pursued from different perspectives but illustrated a common dilemma of feeling powerless even when power was delegated, or a part of status. With this issue it was the quality of the power that seemed to be unacceptable. People did not express power as instrumental in liberating self or others, but rather a burden or a dubious asset.

Each of these issues could be viewed from a gender stance, process and cohesiveness are aspects of the feminine. Not wanting to stand out as having power over others is also about a feminine stance of being a part of, rather than apart from. These issues will be revisited as each research cycle unfolds. I will also consider the role of gender and power as they relate to life strategies in chapter ten.

Managing the research boundaries within a group context.

Boundaries around the research question arose when it was suggested that the 'research would be more interesting if it was about working in organisations, rather than nursing. At the time I thought,

> "Yes I have considered that in some detail and have put it aside. The main focus of my attention is the nurses role and the function of nursing within the organisation. Clearly the organisation can be addressed as a context that influences the way nursing is practised."

I realised that the context in which nursing is practised is changing. Therefore the way nurses cope with this change and support each other is important to the research questions. My assessment was that if the boundaries were not made clear in the beginning stages of the research, then I might get swamped with the needs of others, and the complexity of the data gathered. I was also aware that researching my own nursing role was important to me. Therefore I did not want to get submerged under a plethora of other possibilities. I did want to maintain my focus.

Challenges to the group cohesion and leadership.

Throughout the group session I took a facilitative role and others responded to me as leader. I noticed that people settled down quite quickly when I suggested that we begin the session and although most of the dialogue was directed at me, this was not a problem at this stage in the group's life. It was my knowledge and ideas about what kind of involvement was possible and what I was expecting of them as co-researchers, that held me central.

The challenge occurred around the dilemma between making goals clear and outcomes predictable, and the need to keep the possibilities for surprises open so that new ideas and different ways of working emerged. I am aware that my style of leadership produces discomfort in people who need to have the task very clear before they can commit themselves. This is a dilemma that I have learnt to live with, and consider it to be part of the challenge when new ideas are being encouraged. I have become acquainted with the discomfort of managing chaos and know that I will feel the tension as others challenge this. Receiving challenges can

be seen as a validating process. Being comfortable and sure of the future does not allow the unexpected to emerge. However I did not expect the challenge to come so soon and I 'felt' the impact before I was able to reason with myself. There was an added impact of surprise and anxiety because the challenge came from one of the few men in the group.

Issues that need to be held aside for further information

Some issues that were surfaced during these groups allowed the reflections and feelings that occurred for me at the time, to be recorded. However I realise that noticing when I participate in the research and when in the group process, was important to the continuing group development and data gathering. The key questions that need to be kept alive at the end of this first phase are:

- *how conflict is managed within the group;*
- *the role of gender in group interactions and decision making;*
- *how well I balance the tension between chaos and order.*

I intend to keep alert to situations that inform these questions with the aim of achieving some clarity by the final phase of this first research cycle

Issues that need to be held aside for further information

At the conclusion of this 'Joining Phase', I reflected on both the content and process of each group session and my own personal records. I decided to record some of my ideas to share with the members of the group for several reasons:

- To continue the process of developing a cohesive group by extending the dialogue into the working lives of us all;
- To begin the process of identifying the common issues;
- To encourage action and inquiry in the work context, by presenting questions, ideas and dilemmas;
- To practice being open with regard to my own thoughts and understandings about being a nurse and to invite feedback.

The issues that I chose to reflect back to the group concentrated on the task we had set ourselves, and did not cover any of my tensions anxieties or conflicts. At the time of writing I reflected about this and decided that dialogue within the group is more appropriate to opening up these feelings and issues. I also felt that there needed to be some agreement about how we would work through the more personal ways of knowing and working together, rather than 'setting the pace' myself. I therefore focused on summarising some of the points that we covered. These were:

- Nurses are sometimes caught between taking on a role that places them in an authoritative position in relationship to the patient, and a role that allows a co-operative and collaborative relationship to develop;

- There is often conflict around responding to the cues as a nurse within a given context, and having a particular role of teacher, manager or health visitor within that context;
- Nurses often find themselves working hard to maintain a comfortable climate by looking after and supporting the needs of others, often without recognition, support or a sense of equality;
- Nurses who are managers fluctuate between being supportive and encouraging, and ensuring that confidence is addressed and the job gets done;
- Nursing hierarchies are often in conflict with the authority each nurse requires to do the job well.
- Nurses who manage people often do not have all the information and the decision making power to decide who can, and who can't, do the job of nursing.

This summary of my reflections included a message that I expected the next meeting to focus on developing a clear plan about the encounter phase of the research process, both within the group and in the workplace. This intervention was to punctuate the end of the 'joining phase' and the beginning of the 'working phase'.

Chapter Six

Introduction

This chapter is about the 'working' phase and involves six hours of working together. During this time we developed a group context for individual experiences to be presented and discussed. The questions we pursued about nurses and nursing, required that we share both our personal and professional selves in order to provide the richness of experiences needed to address the questions we were asking. This phase of the group development tested out our ability to develop peer relationships that were both supportive and challenging. The discussions, debates and presentation of personal self, provided the material for developing a sense of ourselves as nurse. Questions emerged and conflict arose. How I dealt with these is both a group concern and a personal experience.

This phase of the group process is written as a total entity. It begins with the introductory presentations by members and ends with the feedback and planning for the next phase. The dialogue is selected in relationship to the issues and ideas that members presented, discussed, debated and inquired into. I used the format introduced in chapter five to identifying my voice and comments, and the voices of group members. My analysis and reflections of this working phase are provided under the headings of:

- Group Developments
- Research process
- Validity criteria
- My personal responses and actions

The working phase

During this phase interactions between members were more open, questions became more direct and challenging, and reflections more open and personal. The pattern for the group sessions was more openly accepted, as individuals contributed their own experiences to the research. This phase was about encountering ourselves, each other, and the world outside the group. In research cycle terms it was the about defining **'the project'** and beginning to **'encounter'** in a purposeful way. Because this was to be the working stage, we agreed to meet for a four hour session in order to take the group process forward. We all agreed that this would deepen our experiences together and assist both the group and research process.

We met for lunch and exchanged both professional and social information, mostly in story form. Some how this seemed more acceptable than discussing experiences directly. This social interaction led into the group work without any direction from me.

The session began with a 'round' of every one presenting 'issues that were on their minds' and some expectations for the way the session might develop. Everyone chose to present a 'critical incident' about conflicts and difficulties being experienced in the work place. These experiences included issues about direct patient care, managing staff in a ward setting,

conflicts between nurses, and conflict between nurses and doctors. After this feedback dialogue began as members raised issues and concerns and others joined the discussion. I have extracted dialogue using the same selection criteria as defined in chapter five.

My voice is in *italics* the group members [GM] in - body text and my comments and ideas at the time are in [text].

DIALOGUE

After the initial round of statements, discussion began with the focus on clarifying conflicting ideas about particular issues related to nursing.

Critical incidents and the nature of nursing

GM -One of the things that struck me, when we were going round the first time, was that we were looking at critical incidents in nursing. I was just a bit concerned that the critical incident that I am looking at is not purely nursing. It really has nothing to do with a nurse. It is all about another profession. Then I reflected on the skills that I used and realised that the skills were my nursing skills. It began to hang more easily with me once I looked at what I did.(pause) I am very conscious at the moment that I am not doing any 'hands on' nursing. Its more management, but then management is so vital to patient care I think.

This dilemma about 'hands on care' has been brought up several times from different points of view. This is the first time someone has 'stated their claim to nursing' because of a set of recognised skills.

GM -I am still a bit hazy about what is a critical incident and how we react to it as individuals. So how is it nursing rather than any individual's way of coping with the situation? How are you going to glean what it is that is nursing? If we find out how nurses react to work situations, how does it apply to nursing?

When this challenge was placed in the 'centre' I felt the impact as a question about whether nursing as a profession really exists. I held that thought for a moment or two and moved my thinking to- "This is a good point that needs to be said" from the point of view of nursing per se and from the personal point of view of the contributor. Was it a statement of not wanting to be part of the group?

Not only is this about, What is nursing? It is also about the interface between the personal and the professional.. It is edging toward. the personal skills that nurses bring to the nursing situation, and those that are they taught as 'nursing'.

GM - It seems to me that the common denominator is that we are all nurses and we may or may not act in a similar way—

This comment was from a member that tends to be more watchful than verbal. She was interrupted by the member who has established a pattern of taking a provocative stand.

GM ---I think it would be just as interesting if we were not nurses because I think that the common denominator is that we all work in a similar organisation. In fact I think that being nurses is co-incidental.

This is again a bid to move away from nursing (and the personal?) and focus on the organisation. There was silence after this statement, I waited. The silence grew deeper and I decided to intervene and bring the focus back to a common issue. I contemplated pursuing the challenge but I felt that the timing was not yet right.. There was a chance that challenging might lead to divisions or withdrawal by some members.

I think we are moving away from the task we set ourselves of presenting our experiences, and reflections, of both out work in the group, and in our own workplace, For me being in the group doesn't allow me to fully concentration because I try to remain aware of what is happening and where the interactions are taking us. Listening to the tapes surprised me and I realise that on the one hand we are a very varied group of people. On the other hand I can identify with each person's experiences of being a nurse. If there is no such thing as nursing, or if nursing is not important to us as senior nurses ,then we need to be clear about that.

This intervention linked with a previous speaker and took the attention of the group back to inquiring into nursing through experiences. My aim was to highlight both difference and common themes. This raised comments about the listening to the tapes and then the focus returned to clarifying nursing.

GM - It is really hard to hold onto being a nurse when you don't actually nurse patients.

GM - But what you do is about nurses giving care to patients. Without nurse tutors there would not be any nursing.

GM - I agree, I know that the way I teach nurses to cope with some of the difficult issues is directly connected to my experiences as a nurse.

GM - I don't think that any of us really speak for nurses. The only peer groups that can speak about nursing are the teams that are based on the wards.

This was a provocative statement and prompted a heated debate about how expertise in nursing is transmitted to learners, and how nurses at the bedside feel unable to get their voices heard. Different perspectives were presented. This demonstrated that the group, as a whole, had a wealth of experience and information about 'hands on' nursing. Gradually the energy diminished and a relaxed pause settled on the group.

GM -In this last hour we have been more open as a group. That's good, because I thought when we first got together as a group that we would be looking at a problem. Then we would all have to talk it through and find a solution. Now I have a different focus. Its on our reflections that we talk about, and that feels much better. It makes it much easier to contribute in the group.

This interpretation of the groups agenda came from a quieter member of the group who had contributed to the last discussion. For me this was double edged, I felt easier because people were more energised and communication flowed more easily across the group, but I had an 'itch' about making it easy to discuss experiences that are already filtered.

It was not long before tension arose about the focus of our intent. The tension was between tasks that are goal and solution oriented, and those that are more process and interaction oriented with solutions arising out of the process of doing.

GM-That reminds me of some thing I have been writing about in a different context. If you asked people what did Einstein do they would say that he discovered the theory of relativity. How many of you understand what the theory of relativity is?

Again this intervention came from the member who tends to cut across the group discussion with an idea that does not appear to flow out of the interaction. In keeping with previous interactions of this kind there followed a tangible and tense silence. I decided to wait and see what evolved. I noticed that nobody gave any signals that they were interested, neither did they show resistance. This reminded me of work situations where doctors 'take the floor' and pontificate to junior doctors, completely ignoring other professions and the patient concerned. Whilst I was pre-occupied with my thoughts the speaker continued to explain the laws of relativity. I was struck by a sense of incongruity in this stance. I felt myself resisting and realised that there was something more than incongruence that I was wrestling with. I returned to this dialogue at the end of the 'working phase' and decided to record the actual transcript.. It held a questioning that needed to be revisit later in the research journey. That is why the total 'speech' is recorded here. It will be revisited when I tell my own stories in chapter twelve.

-It's quite interesting in a mechanical order of things A leads to B leads to C but what Einstein suggested was that A can lead to B,C,D,E, or any manner of things. An explosion of ideas and information, and I think to some extend the whole of nursing wants a medical model-problem-solution-solved. It was the way nursing worked for a long time, everything was reducible to the simplest of terms. Where as nursing and nursing models are about caring and it is difficult to define. Then B does not fit into the pattern and there are no easy solutions. Where as when you come into a group, you've a got a problem, and you hope that you can all work on the problem and go home. Because at the end of the day, if any one asks you about the processes the group went through, or suggested that there might not be a solution, then it starts getting into this relativity field. What happens then is all these awful ideas explode inside your head, and you try to put them together again. You say "Where do they fit in?" and then you say, "Perhaps I am deviant because I cannot think of a straight forward path in this".

That is where all this is coming to for me. Some of us panic that at the end of an hour we ought to have one of the walls painted. We ought to have a result. What worries us even

more is that everyone else ought to have a result. We worry about others not having a result too. We sit in a meeting saying, "I hope they she is getting something out of this." Well I think that is their responsibility to a greater or lesser extent.

There was a long pause after this monologue and I did not break it. My overriding thought at the time was that this speech was not intended to create a dialogue. It had the tones of authority - something about not needing to discuss but knowing. There was also something else that stopped me responding. If I spoke to someone else then that would be a slight on the person who had spoken, and if I spoke to the person himself then I would be risking another monologue. My sense was that the group did not want to pursue the ideas that were presented. I said nothing and caste my eyes around the group. Someone broke the silence. My analysis of this at the time is different than the way I see it now. I realise now that the anxieties about groups being successful, being 'in charge' and needing to demonstrate clear results, are all part of the struggle that nurses face. There is also the challenge to my need to stay with the chaos and confusion while we work towards a sense of group identity.

The silence was broken again by one of the 'listening' members,

-I just wonder what other groups of people would be sitting round reflecting like this. I think that it is because we are nurses that we are here now. I can't imagine doctors taking the time to sit around reflecting on their roles as doctors.

I am now struck by the way in which this member guided the group through some difficult situations. I realise at this point that she has an important role to play in this group- Harmoniser and initiator. Her interaction at this point encouraged others to participate again.

However in a very short space of time the original speaker again took the dialogue away from sharing experiences, to stating facts this time about 'nurses wanting predictable results when they attend any lectures or did research' . I pondered whether this was a challenge to the research methodology or something that is happening in his own life. I considered inquiring. While I was pondering how I could do this without getting into a confrontation another member took up the challenge.

GM - My experiences don't feel like that (nurses wanting predictability and results). I know what my problem is at work and I know what is causing it. I did not come here to have someone tell me about the solutions, I know what the solution is. It is the telling of it that is important, or not the telling of it, and it is having the time to talk about it. You don't sit down with somebody, a friend, and go through a two hour conversation and want a solution at the end. You just talk. The group to me is talking for the sake of talking and that is helpful. I can find the solutions myself.

I am aware that this person works with the person he is responding too as one of his team. I realise that some of my reticence to challenging is about opening up issues that will be difficult for others to enter. This kind of censoring exists in work groups where there is a

hierarchy. More junior nurses feel unable to 'speak out' in the hospital ward setting just as we are finding it difficult. The consequences of being part of this kind of hierarchy, and sharing the same work setting, is discussed at the end of this research cycle.

This was a welcome difference and released the tension allowing others to voice their thoughts about what is acceptable to talk about. Group norms and boundaries then take focus.

Group norms and boundaries

GM -I'm picking up on what you just said and I think it is something that I am wanting to say. In a way I think I am waiting for some sort of permission, or the boundaries that one can go to with this discussion. I am still feeling my way for some idea about what sort of discussion it is going to be, and about what. I am not looking for solutions but I am looking for something like permission, freedom, boundaries.

This 'testing the water' comes from a nurse manager who has been having difficulties in relationship to authority and responsibility.

-Perhaps if we are sharing our reflections we are seeking approval for our own feelings.

This opened up dialogue about showing feelings and testing boundaries.

When the energy for discussion slows down I suggested that we move into small groups to share 'critical incidents' in more detail. I suggested that we focus on the techniques of action and reflection and the context in which critical incidents emerge. This is followed by a large group feedback. We again deviated from the process when one member moved from giving feedback to discussing his anxieties about the changes in nursing. In particular the shift from nurses being clear about what they have to achieve in the way of tasks, to now being given responsibility for their practice. The conclusion that this member came to was - -

---So that they now believe that they can do just as they like and are responsible to no one.

This point of view was presented by the same person who presented the Einstein theory. I was again left wondering where all this conflict and negativity was coming from. This time there was a quick response from several members.

GM -Even if responsibility is devolved people are still accountable aren't they?

---We don't even know what accountable means.

GM -You mean I am not allowed to say that I do?

---No the majority of people do not know what accountability means. Mary Manthey at the sister's conference made it clear to me. She said that authority, accountability, and responsibility are sequential, and you cannot have one without the other.

This was another statement that did not seem to seek a response. However, previous to this statement, various points of view about the nature and function of accountability in nursing

were proffered. Therefore I decided to present my own point of view rather than hold back to avoid leading 'from the front'.

-I disagree Neil I believe that you can have responsibility without authority. That is what often makes decision making difficult for nurses. It is very difficult to be accountable for the nursing you are responsible for if you have no authority for the decision making necessary to get the work done.

After further discussion I asked the group to complete the process we had started.

Can we carry on around the group so that everyone has a chance to give some feedback?

The feedback on the small group work continued. The next dialogue is directed to one of the members in a small group. It refers to why he did not get too involved in discussion.

GM -The particular incident that you described rang a lot of bell for me. I sat there ticking off in my past where I had experienced similar situations. What I was hesitating to do was to say- "Oh yes I had a situation like that", and then take away from the value of your situation.

So it was important for you to respect that a situation is familiar but unique to the person------ is that about keeping a balance between empathy and respecting the uniqueness of a persons experience as it happened?

I join the discussion at this point because I am interested to take this idea of 'owning one's experience' a little further.

GM-Yes I think that it is important not to take a person's critical incident and contaminate it with you [your experiences]. That would be a mistake. You have got to allow the person's incident to stand on it's own. Allow it to keep it's freshness. That is an important reflection I think.

This was a useful pointer about how to respond to people who are presenting a personal experience that may, or may not, be satisfactory to them. To try to change the framing may not be useful.

GM -I found it interesting that in our group we started as a whole group and then we split into two halves. This gave us opportunities to have very productive conversations about experiences we shared.

GM -I felt that would not have happened in the large group

GM - Yes it broke off into personal agendas. It became two people talking instead of four.

And dealing with histories rather than what is actually happening- it is about now but also about unfinished business. I think it was very useful because those things need to be sorted out.

I was involved in this group and some of the 'unfinished business' was about my role in a change project with one of the small group members. It was important for both of us to review that experience and to acknowledge that the present situation needs to be different.

This dialogue continued until all had reported back. I then summarised my view of the process and the issues from my position as facilitator.

-There are two things on my mind that I would like to present to you. One is the issue of power that seems to surface every so often. I do not know if we should focus on power as a concept or as an issue. It seems to me that is going to keep coming up so perhaps we should agree some common language together.

There is also some energy for talking about personal issues like - How much do we share the things that we are concerned about? Then I think there is something about critical incidents and how we support each other so that we really do look at what nursing is or isn't.

These are my reflections about the issues that we could take forward. Would anyone else like to put some ideas into the middle?

GM -I think it is going to be very difficult to cope with our feelings when we talk about critical incidents. I think that this is something that we are going to have to negotiate in the group, because recalling critical incidents is likely to cause some emotion, some feelings, and these feelings could be painful. I do think we need to have some agreement about how we work through them.

GM -I don't think I feel uncomfortable about hearing about something that is painful for you. What I am not sure of is what you would want me to do about it

There followed a discussion about our own feelings and emotions and how we would want these responded to. This was discussed particularly in relationship to power.

GM -I think the other concern is- Do we talk about it in an abstract way as a principle, or are we free to bring in any personal experiences and the conflicts that we are having about it? (power) Can we really feel safe when it could become very 'people' oriented and quite dangerous really?

-My feelings about that division, is that if we talk about something that is abstract then I think that we should put boundaries around it, define it, and agree to explore it.. If we are talking about power in our own lives,and work, then that is very different. I feel a sense of rejection when I bring a personal experience to someone and they analyse it. It is like having my experiences devalue.

This statement comes from me as a member of the group not as a facilitator. It arose out of my own personal feelings of frustration at some of the abstract ideas that cut across discussions personal to me and, I sensed, to others. I am aware now that there is a genderedness about

the way I hold back the hard analytical and task orientation, in favour of looseness and exploration of personal experiences.

This led into a discussion about the need for trust amongst us.

Vulnerability and managing emotions

GM -This should be a trusting group but it doesn't just work like that does it? I am quite concerned about you misconstruing what I say. After all you are my boss.[directed at me] I know we have joked about it before but it is the truth isn't it? The way I am going to find out is whether you do misconstrue what I say. Starting from an optimistic basis that you probably won't.

This concern is made by a member of the group who works with me. It was an important interaction between us.

What would you like me to do to re-assure you that I am not misconstruing what you say?

GM -I don't think you need to do anything. I am going to do what I am going to do and I will learn from what you do because it is in action that trust is developed.

And I would hope that if you are doubtful about what I mean then you will ask me.

This initiated a discussion about trust and about being misinterpreted, misunderstood and taking risks to test trust.

GM -I feel that we do not have to start at base one here, because the characteristic of this group is that we are a group of experienced and successful nurses. I don't feel that I have to be hypersensitive. We have all developed competent ways of coping.

This was stated by a male member of the group and I watched as some of the women moved forward to engage. I expected gender differences to emerge as concern about showing emotions became the focus and led into disclosing personal feelings. I took this opportunity to test whether a change of pace and focus might be appropriate. Ask the group to consider whether they would find it useful to move the focus towards opening up the personal side of who we are as a way of understanding each other better. I offered to present my personal self to the group through the memories that travel with me. (I had come prepared to present the echoes of interpersonal relationships in my past that still influence and strengthened me as I worked as a nurse.) A few people showed interest but I realise that the timing was not quite right. I let go of the idea for the moment.

A critical incident was then presented by one member in which she experienced uncontrollable emotion through a self awareness activity.

GM -This experience told me much more about the power of group work and a lot about myself. I did not think I could relive the pain to that degree.

GM -I think for me that confirms what I want to say to you Mark. Even experienced nurses of 30 years can be vulnerable in certain situations. I can't be confident that you won't find my Achilles heel. Particularly if we get into these power discussions.

This was very interesting because it implied that personal issues of power were emotive. Also that unfinished business from the statement about "all experienced nurse--" had touched a concern about 'showing emotions'.

There was more discussion and clarification of different concerns and expectations. Finally the initial statement was challenged.

GM - I thought you were saying that as experienced nurses we should be able to handle emotions?

GM - No, what I was saying was 'Stick with it and show that you can stick with it"

The focus then shifted to a discussion about management and changes in health care. I took part in this interaction and did not pay much attention to the process. I felt relaxed after the issues about emotions had been surfaced and resolved- I thought. Gradually the conversation petered out and their was a prolonged silence.

Again the quiet member who always seems to be ready to reflect and re-focus commented on the process.

GM - Well since tea time I do not think we have got any further. Before tea we seemed to be getting closer. We were talking about trust within a group and I was about to say what I would find difficulty sharing. Then we went on to something else. Now I do not want to share it any more, I have just lost track.

Is there anything we could do to bring it back?

GM - No, I am not sure what we are going on to now.

Murmuring of agreement.

GM -May be we just need to fire it up again?

GM -I think it is really a physical problem. Four hours is a long time and the climate does not help concentration. I cannot concentrate for more than a couple of hours. I think we should pack up. There isn't any energy to keep it going.

This bid for closure came from the person who has challenged my leadership, I thought, on several occasions. I therefore decided to respond assertively.

About half an hour ago I asked you if you would like me to present something about my own personal history and the people who have influenced me at different times in my life. I would be willing to share it with you now if it is this a good time.

Most of the group showed interes and the energy began to flow again. However, I was aware that there was still unfinished business.

GM - Before we move on I wanted to check something out. What I said about people crying seemed to stun people a bit.

This was an important intervention as it was one of the men in the group checking whether the way they presented their ideas had affected the some of the women adversely.

-No that did not worry me, I would not worry about crying because I would think the group would support me if I did.

Others contribute to this and there are some veiled comments from the women about being seen as emotional. This led into a feedback session about why the focus moved away from personal issues, to management and organisational issues. Group members offered their perceptions and ideas about why this had occurred. My personal belief was that these personal issues connected with the issues about change and the difficulties for nurse managers to cope with the conflicts. However I did not pursue it from this frame. There was another analysis from one of the members that was appropriately timed.

GM -The conversation went into management issues and removed us from the process by focusing on issues outside of the group. The conversation before that was about "How do we handle ourselves if things get too personal? It is interesting that now we are again talking about, "How does the group learn about handling things?" people are more interested in what is going on.

-So are you saying that we need to monitor this occurring more carefully so that people are not excluded and the real issues avoided.

GM - There is trouble with monitoring things. As a facilitator you can be too much in control. If the group takes something in a certain direction it has gone there for some reason. To stop it might inhibit something that is happening in the group. I think it went in that direction because people were feeling uncomfortable. Julie brought it back and now it is OK to re-look at it

This opened up a very active discussion about nurses not being able to show their feelings and therefore not being authentic. This then leads to angry and guilty feelings about the situation that evolves.

GM -It is not so much the expressing or not expressing anger, it is more about handling your feelings afterwards.

GM -As a child I was very frightened about how anger affected my behaviour and how dangerous it was. I tried to control it by being withdrawn and calm. Now I try to be more real.

GM-Genuine anger is not the same as managers portraying anger to manipulate others to do things.

GM -When I control my anger it is often because it is not acceptable to others. That leaves me feeling very uncomfortable because I have not been true to myself.

Discussions about anger led on to concerns about conflict. I let this interaction find it's own path and joined in.

GM -I have used the word conflict a lot in the past and people have found it a very aggressive word. To me it means a challenge, its a part of life, but for a lot of people conflict is very heavily negative and aggressive.

GM -It's a bit like the word 'power'. It can be something that you shy away from and yet it can be something like conflict. It depends on the situation.

GM -A few years ago I would have backed down from any conflict for fear of upsetting other people or being upset. Over the years I have come to see that conflict is necessary to get to bottom of things, it's a process that you have to go through. I have found that people who do not view conflict as being both positive and negative, view it with trepidation.

GM -It is certainly a situation that you do not want to remain in. If you find yourself in conflict you want to work to get out of it

For me conflict occurs as a natural process. It is a part of getting to know people and forming relationships. It is also about people having a different perception about a particular reality and needing to sort out the differences and similarities .

GM -Yes, that is important, conflict needs to be worked through doesn't it? It can be very helpful if it is worked through.

Personal life stories

There is a natural pause and agreement that a 'change of pace' is needed and I present my personal history. My aim in doing this was to open up the possibility of an 'inward search' about who we are and to take some risks as a way of opening up new pathways to research.

This presentation was about my life history and the people I 'carry' with me. The material was presented on overhead transparencies allowing for both focus and discussion. Three frames were presented and included voices from my personal past, voices from my working past and the principles that guide my actions. I used each frame to explain how these voices and the principles influenced my developing life. There were some questions as I presented but the main discussion occurred after my presentation.

GM - I found that very helpful because you tested the honesty about your vision. There were some things that I immediately resonated with, and there were a few things that I would immediately get into conflict with you about. I imagine that would be true of any group.

This was a subtle change in contribution- this was from the person who, up until now, had challenged ideas that were of the feeling, experiential and intuitive kind. This was a very

'straight' statement and I wondered - Why the change? I consciously put the dilemma aside to think about later. Others contributed to the discussion.

GM -I am interested that you remember statements or quotes. I spent a lot of time thinking,, Now is that what I remember? -- If I was to map the critical people in my life it would have to be incidents, or my explanation of situations.

This was important as it punctuated the nature of our personal selves. How we develop a sense of being in the world and a way of managing diversity and everyday situations.

A discussion followed about the usefulness of sharing our personal selves through our own stories and the meaning we make of them. There was a willingness to continue this activity in the next group, with several members offering to take a lead. Expressing individual lives seemed to hit an accord and provided a pathway for sharing self without becoming uncontrollably vulnerable.

Conclusion

The day finished with each member giving a short feedback and a commitment to bring a some reflections from work to the next group and to consider presenting their own 'personal journey'.. We discussed how to manage the data on tape. It was agreed that each person was to have the information as a basis for thinking about their own research activity. We also discussed whether I should try and make sense of each tape and send out a summary. The conclusion was that this might be misleading. I then offered to make a copy of each tape for each member of the group. Everyone agreed to this and I affirmed that the agreement was for all members, whether they had attended the group or not. [At this meeting all the members were present] This was a promise that I found extremely hard to keep. I did not realise copying twelve tapes took so long, or how difficult it was getting the tapes to people in a timely way.

Interpretations And Reflections

The group development

In reviewing the group development I used the process observation guide (Research Preparation fig 1) as a tool. I notice that my interventions were fairly evenly devoted to getting the task accomplished and encouraging interactions, possibly more towards interactions. I noticed also that my interventions of a directive kind were tentative and over ruled twice in favour of returning to issues about whether showing emotions was an acceptable. I noticed some restlessness in people as one member held a central position for some considerable time. I did not comment about this because I did not feel it was timely to do so. One member of the group did and said, " ---- why do you stretch every idea to it's absolute limit" The reply was, "What do you mean?" There followed silence and a change of topic. This was a well aimed probe and no one in the group sought to pursue the intervention.

Group members were very open about checking out the norms of the group and how much they could trust each other. I believe that much of the process work needed to allow tasks to be addressed was accomplished during this working phase. During the final round of feedback group members demonstrated an eagerness to make a commitment to action and reflection in the work place in preparation for the next session.

The research process

This stage of the research cycle produced a sense of focus for encountering the work context., As a consequence Ideas about nursing, and being a nurse, were tested out. We gained an insight into the quality of knowing that was required to effectively pay attention to both internal dialogue and interpersonal activities. Several group members presented ideas that they wanted to test out. However, much of the focus for risk taking was about encountering each other and what that meant for the world of work. The effect of this encountering seemed to be that group members felt more positive about using the skills of action and reflection and bringing back their observations to the group. Personal life stories seemed to connect with an important part of being a nurse and the use of self as a tool for working with people. The importance of being self-aware became central to noticing the interplay of ones own actions and feelings and those of others.

From my own reflections and the recorded data the following tentative propositions have been extracted. They relate to both the research intent and the methods used They are as follows:

- nursing is a set of recognisable skills;
- research is more about reflection and action than instant solutions;
- personal critical incidents should be recognised as unique in the telling;
- it is important to be authentic, allowing feelings to match actions;
- identifying the issue of power and authority in nursing is complex.

During the session there were several challenges from more than one member of the group.. These challenges included the purpose of the research and a bid to move away from nursing to 'the organisation'. The purpose was re-affirmed and no one in the group took up the challenge to change the focus. However I did not directly put the choice forward. I paid attention to issues that had a sense of genderedness. These issues were about being vulnerable, expressing emotion, allowing the dialogue to flow with out achieving a tangible goal, valuing personal experience as unique and valuing the interaction for its own sake. Group members demonstrated more confidence in reflecting in the group and inquiring of others. As this occurred issues were pursued and themes emerged. At the end of this phase each member made a commitment to identifying their 'encounter' within the world of practice.

The interpersonal skills and research tools were discussed and practised and I addressed the need for personal reflection by presenting my 'personal journey'. This engaged the group and

encouraged a sense of mutual understanding. We agreed that understanding the personal self was important to understanding and developing the professional self.

Validity Criteria

I did not surface any issues of validity directly although I did take notice of incidents that might inform the validity criteria. My analysis is as follows:

Collusion:- There was no evidence that patterns of interaction were emerging that gave strength to any one persons preferred ideas, or that small groups were emerging with particular agendas. Members of the group, who worked with each other, mentioned their connections and stated their awareness that this might be a problem. It could be that the 'silences' around one members contributions might have been collusion. I am inclined to see this as either 'out of context', that is, referring or focusing on something that is somehow the 'property' of the individual who is presenting it and not for discussion, or somehow incongruent with the focus of the interaction that is occurring. At this point it is necessary to hold my analysis to one side and wait for events to unfold.

Unaware projections For some member of the group, including myself, there was unfinished business from past experiences. The small groups were useful in providing a means to sort these through (there were comment about the usefulness of this). I was also aware, as I am sure others were, that conflicts and difficulties were part of the lives of individuals and sometimes nfluenced perspective and intensity.

Authenticity There was some discussion about being authentic in the work place, and how one knew when this was not happening. The question of being able to express feelings, and the acceptability of this to the group, was explored. There was also some discussion about interpretations of feelings and the responses people wanted from others.

Coherence in action I was acutely aware that the way I worked in the group mirrored my interventions in my own workplace aimed at encouraging a learning culture. The way I set up the group and managed the phases of group development was about fostering risk taking and personal confidence. I was aware of the different feelings and thoughts that ran through me during the group sessions. However, I did not necessarily allow myself to speak or act on all that I experienced. I did make an effort to consider what was appropriate to the mood. the focus of attention, and the stage of group growth. When I planned to interact I was clear that the perspective I was taking was congruent wiith my thoughts and feelings. I do not know whether this was how others perceived my interactions and I did not always plan the actions I took.

My personal responses and actions.

I found this phase of the research cycle rewarding. I was very relieved that issues of group process, and group norms, were discussed and tentative solutions found. At times I 'pushed' decision making around the ground rules, the use of the research tools, and the management

of the group session. I worked to establish interactions that did not focus on me as leader. This is because I believe that if a group manages to get through the working stage with energy for action, then I as a facilitator can be more active as a participant.

There were some issues about power, gendered roles, unclear agendas, and unspoken conflict that caught my attention. However maintaining divergence rather than seeking convergence, seemed to be the best strategy at that time. There was also a sense of struggle over the direction and the journey and lack of openness about the 'baggage' that all of us carried. Although some of this was unspoken shared knowledge. This I realise is also a part of the lives of nurses and mirrors my experience of working in the clinical setting.

I decided to bring to the next group session my actions and reflections about situations at work where power, unclear agendas and conflict were present. Although I view conflict as a natural process in developing working relationships, I also know that where power is used for personal gain it is important to manage conflict in a way that encourages co-operation. This I have experienced, and wrestled with, in the context of work.

This working phase prepared us for using the research tools of action and reflection in the workplace. It also prepared us for the knowledge seeking phase where identifying, how we know what we know and how new knowledge can be generated through personal experiences.

Chapter Seven

Introduction

Before I begin to write about this Knowledge Seeking phase of group work, it is important I record the process that has brought me to this point. I have already made clear that this field work began in the first year of my studies and therefore should, and does, reflect changes in my own thinking and doing. This chapter more than any other, has required that I return to the original data. The meaning I made nearly two years ago, no longer makes sense. With the same purpose that was agreed with my fellow peers I have revisited the original data and extracted 'live' records that identify the issues and themes as I see them now. It is not so much a change of interpretation but rather a deeper sense of how the data speaks about the experiences we shared together and about nurses and nursing. In part this has been influenced by my realisation that setting up peer groups for support and appraisal is fraught with difficulty, and cuts a furrow across the way health care organisations regard the nurses role. [One could say that if it was easy then it would be happening quite freely!]

This knowledge seeking phase began at the point where the group members were ready to test out their own planned experiences. The three indicators that prompted me to move into the 'knowledge seeking phase' were:

- the enthusiasm to explore both personal and professional sense of self;
- the desire to use the tools of action and reflection;
- the ease with which most members were able to recognise work situations that represent aspects of nursing to be researched.

The central focus is the development of practical and experiential knowledge (Heron 1981) about nursing and being a nurse. This involved each member paying attention to particular issues at work, within themselves, and between each other. As co-subject and co-researcher, I participated fully by agreeing the issues and presenting my own personal experiences as part of each feedback session. During this phase group members requested time to tell their personal stories. All but three were given time. Some members developed support groups with their colleagues and peers in their own work setting.

Before the first group session I took some time to review the data available at that point and contemplate the possible paths that might unfold. I reviewed the research processes in terms of the patterns and ways of working that had emerged. I also assessed the group development in terms of meeting my initial criteria for a peer support and inquiry group. These criteria were:

- maintaining the balance between task and process;
- bringing into shared consciousness the tools of action and reflection;
- managing the issues of conflict, leadership, gender, trust, power and boundaries;

- establishing a pattern of working together that identified issues and themes.

I also added:-

- a healthy tension between security and vulnerability keeping in mind that support groups can stifle challenge and risk taking.

I then considered how I had coped with the conflict and leadership challenges and I acknowledged that although conflict had not prevented the group developing, there was unfinished business that I needed to address at some point. My intuition encouraged me to wait until the interaction between members was more of a 'risk taking nature' and then take up the challenge in a more direct way. I was not sure how confident I was in defining the difference between challenges to the research methodology and challenges to this style of learning. Somehow I needed to inquire into the concern within a challenge. Whether it is the difficulty in holding ideas aside to discover new ones, or whether it is about seeking grounded knowledge that is derived from practice, or something else. I expected group members to take a more assertive stance in pursuing ideas and issues. Therefore, as facilitator, I would need to pay attention to when I intervened as a facilitator and when as a participant. It was clear that we needed to have some shared understanding about nursing practice, and how working together as a group might support that practice.

Having reviewed and clarified my own ideas and intentions. I decided that certain processes, tasks, and activities were important to encourage or notice. Therefore the following became a guide to my noticing and reflecting:

- affirming and noticing the patterns and style of working together as researchers and as a developing group by using the activities of sifting information, inquiring, noticing internal dialogue and agreeing similarities and differences ;
- encouraging members to take responsibility for task and process issues;
- maintaining the two main strands of personal journey and critical incidents to produce the data for identifying themes and issues;
- presenting my own personal experiences and taking risks to support others in doing the same. (I personally consider that risk taking is more likely to produce new knowledge because the outcome is not predictable and therefore can give rise the unexpected.)

I expected that patterns and themes, similarities and differences, and issues of validity would arise in this phase where inquiry is the medium for knowledge to develop.

The Knowledge Seeking Phase

This phase of the group work included four session over a time span of four months. Each session began with creating an agenda through clarifying the needs of participants and agreeing priorities. Feedback information was framed in ways that encouraged dialogue and

active participation. This in turn fostered the testing and building of ideas. As we became more focused, so the issues about being a nurse became clearer.

At the beginning of each group session we tested out some of these ideas and by the end of this group phase we agreed that the following issues held a sense of importance.

- The anxiety that arose out of using the research methodology.
- Personal lives and feeling interpersonally competent.
- The genderedness of power relationships.

Coherence and authenticity as measures of validity. was woven into the total dialogue and emerged out of actions and reflections that raised anxiety as we recounted our thinking feeling and doing.]

The dialogue that follows is organised to focus on these agreed issues and is not in time sequence. I have used the same selection criteria as defined in chapter five.

My voice is in *italics* the group members [GM] in - body text and my comments and ideas at the time are in [text].

The anxiety that arose out of using the research methodology

The appropriateness of the methodology to nursing is a theme that runs through this first cycle of research. It becomes an issue through the use of tape recordings, reflective diaries, and the idea that nursing knowledge is grounded experience. This dialogue is focused on the use of the tape recorder as a research tool and raises issues that caused anxiety and conflict.

Dialogue

[The group began with talking about the use of the audio-tapes for feedback, reflection and interpretation.]

GM - I listened to the tapes and it was fascinating to relive the experiences again. I have also written some reflections about the last day, I experienced quite a lot of emotions, especially when I reflected about what has happened in my life to make me what I am.

This comment is made during the beginning round of 'placing agendas in the middle'. Consequently I refrain from inquiring and the focus moves to the next speaker. Other members give their references to the last session and then the speaker continues.

GM - There were a few specific happenings that I could remember when I reflected on my life. When I listened to the tapes I recalled incidents through reliving and remembering them. I thought about how much I was willing to share these experiences. First I recalled only bad things, and I thought, "I can't bore people with that" and, "Am I really prepared to share the emotional things?" After I had listened for a while I began to recall the positive things. What I am prepared to share are the milestones, as long as the group is prepared to listen. I think it is going to be significant either way.

There was general encouragement within the group. However, before the invitation to continue was made clear the use of tape recordings became the focus for surfacing a range of anxieties. The first concern was about people listening to the tape of a group they did not attend. There was some discussion about this, and about confidentiality. However the anxiety seemed to be about being misinterpreted.

GM - .I had that anxiety last time, and although I think it is OK that people listen, I want to be able to say no if it is really important to me.

I have been thinking about that possibility . What would make you want to say no?

I realised that this was an important issue, and I had a sense that for others hearing ones 'voice', had wider connotations. The speaker voiced various situations where it might be a difficulty and then finished with--

GM - There is nothing I can really put my finger on it is just knowing I can say no.

GM - I think it is all right for people to hear because we will know more about what we really think if we can comment openly and know that others respect this.

There was a pause after this statement and then a few nods around the room. I then moved away from group process and made a link with managing the research process.

GM - I think the tapes are an essential part of the research process because they capture much more of the dialogue than any of us can remember.

GM - Yes, I would agree with you on two counts. The first is the importance of having a second view of the situation that we have been through, and the second is about who comes. If people do not have an opportunity to listen to the tapes they will become more and more isolated from what is happening. Then they won't feel that they can have an input into future meetings.

This led into changes in interpretation from being in the situation and then listening again and again and possibly interpreting differently.

GM - The fact that some of us are sitting here instead of the whole group alters the way you feel and the way you think.

GM - That always happens where ever you are---

GM - Even at work there is no possibility that everyone can be present when an issue is discussed.

GM - I think a tape recording is better than relying on others opinions. At least you hear everything that is said.

I was aware of the energy flowing, and realised that there was more than confidentiality, and tape recorders, being discussed. There were issues about decisions being made without

everyone present and statements recorded and perhaps used against you. I suspected there was another hidden agenda, the fear of being wrong and held to account. Whilst I was reflecting on these issues I realised that much of my thinking was from my own experiences and my understandings about the way gender operates in organisations. While I am reflecting on the implications of this the conversation moves on.

GM - For instance, myself and Susan may violently disagree about something. If you asked us week by week about that interaction, both of us would shift our perspective in the light of new experiences. Even if it was on tape. Additional information, plus our ability to sift, filter and place that information appropriately, makes it different. So it may start off as a series of ideas that are not really very important and by reworking, becomes a much stronger idea.

This statement was being presented in a confrontational tone but I listened and heard a logic worth pursuing. However I did not respond at this time but, on reflection now, it was quite prophetic. This person was the subject of the conflict I revisit in chapter twelve, and made sense of in terms of the issues facing nursing.

The conversation moves backwards and forwards through the value of sharing with everyone and learning to trust each other; to the discomfort of being miss-interpreted or just hearing oneself on tape. As the dialogue becomes more personal conflict arises and one member takes the focus away from acknowledging personal feelings, to a more abstract point of view. This is counteracted with a challenge to acknowledge the feelings that accompany the interaction and not destroy it by analysis.

GM - Yes, but what if you press the tape and you hear the interaction, and the feelings that accompanied that are re-experienced? It is only when you start articulating those feelings that you get a different perspective.

GM - That's what this kind of research is about isn't it?- hearing someone else's point of view and being able to shift your own through rethinking and feeling.

It's being open to that.

GM - I am just wondering what is the point of all that if you are just shifting all the time?

This is a person who is involved in ethnographic studies for her PhD and is beginning to doubt her own research methodology.

What are you getting at?

I think I am thinking from a research point of view. If things are always shifting what are you going to present?

I had to stop and think at this point. Firstly about the kind of research that she was involved in. I did not want to cut across it. Secondly because at that point I was feeling overwhelmed by differing points of view and levels of communication. Eventually I gave a bland response

about research being a journey and that 'looking back' I will probably make more sense of it. Others actively joined with this sense of change as the journey progresses.

GM - Any piece of research is a snap shot of what is happening at that time, however empirical it is, however hard and fast the rules.

This was reassuring, but a statement rather than an inquiry, and brought a response from the original inquiry about presenting a coherent piece of research.

GM - Subject to your skills and abilities at that time. [Prophetic for me]

This was followed by a testing discussion about what we really thought we were doing, and how all the different things that we were presenting could make any sense at all. I decided to re-affirm the focus and give my point of view.

If we, as a group of nurses, feel that in talking out the issues in this setting we can actually support each other in a way that helps us provide a good nursing service, then we have achieved the initial goal. If in sharing ideas and personal issues we become clearer about the strengths and abilities we have to be people and nurses this should also reflect out ability to listen to each other, shift our perspective, and develop a clearer sense of what nursing is for us. So I think that recording what we do and say, in this setting, is about who and what we are as nurses individually and collectively. That is what this research is about for me.

GM - If we can talk about differences of interpretation here, then may be that will give us strengths to confront some of the difficulties at work. But we need to test it out by being honest and open with each other, or it won't be of any use.

This idea seemed to release the concern that underpinned the discussion about the use of tape recorders. A discussion ensued making mention of a confrontation that occurred in a previous group when one of the key members involved in the confrontation was not present. As follows—

GM - Listening to the last tape one thing that I was quite uncomfortable about was talking about Colin who was not actually present. I wondered Colin, what you felt about what I said on the tape? [This intervention is directed at Colin.]

GM - Tell me more. I am not sure I remember that bit.

GM - It was the group before last when I felt you were speaking on behalf of Susan and me. Having discussed it at the time I felt we had a better understanding of it, but I did not check with you.

GM - I remember, I often feel discomfort when I place myself in a leadership position that I don't own, but I feel robust about making mistakes. Sometimes I am embarrassed but I get over that.

The previous discussion had been about reporting back from small group work where Colin spoke for the group. This makes me very aware about how tentative nurses are about moving across boundaries or confronting the unspoken rules about discretion and ownership of ones own thinking.

[Other members of the group joined in this discussion, elaborating on what happened from their point of view.

GM - I remember, we did talk about being able to make mistakes and learning from them.

GM - I still have a tension about talking about other people, or naming people when they are not there. Although I think you are right we should be free to talk from our own point of view.

GM - I don't think we should speak for people, or make judgement about what people say, but I think I can speak for myself, and what I felt at the time without undermining anyone else's opinion.

GM - I think I can pick up on what you are saying. If I have a problem about it - if I am feeling angry or hurt then I think it is important to say it to the person concerned rather than somebody else. If you can't say it to the person it is probably better to say it to somebody that you can trust.

This is the person who brought up the issue in the beginning and she is stating that her analysis of the situation has changed. It is also an issue that is not usually addressed i.e. What does one do with strong feelings that cannot be reflected back to those primarily involved? Is this a move towards being more honest with each other and acknowledging that we need this kind of support to cope with containing emotions? My reflections are tentative and not verbalise. The focus again moved back to the initial concern.

GM - Yes I think it is the notion that it is being tape recorded and those people may or may not hear it, and by the time they do hear it the meaning of the dialogue is gone.

And then after you have listened to what you actually said -does it make it better or worse?

GM - Worse, because I don't know how it will be interpreted.

Perhaps we could test it out on the people who were not here last week and did listened to the tape. I am seeking closure at this point.

Colin - Personally it makes me feel better hearing others perspectives. It gives me more to bring to other situations

GM - Part of that is knowing you are not the only one that is having those difficulties, but also being able to increase you 'tool kit' about how to manage those difficulties

GM - I remember it coming up on the tape and it just reminded me of the original conversation. I did not know if Colin was at the last meeting, but it did not strike me as a problem like-"Oh I wonder why Colin is not answering." When my name was mentioned I pricked up my ears, but

then I thought "That is the whole point of it. We are being taped" and I felt quite happy that it could be used in any way the group wanted to. It was a strange feeling hearing my name mentioned, but it didn't particularly worry me.

This is from one of the members who does a lot of listening and often brings ideas together to re-focus attention.

GM - It is such a funny feeling hearing yourself afterwards on the tape, it is bad enough here. I thought "Oh god why did I say those things" I felt a slight discomfort at revealing about my childhood because they are very private experiences, and I think- "well were they relevant really?" It does make me fell a bit uneasy when I hear it.

GM - But surely that is the whole point. If they are relevant to you, and they contribute to what you are now, then it is important to us as a group that you have trusted us and shared yourself.

The above dialogue was a key aspect of this phase of the fieldwork and is presented as a way of providing the reader some insight into the concerns and discussions about the research tools and how this focus uncovered other anxieties and agendas. The use of reflection for action and in action was not brought up as a problem until the final 'sense making' phase.

Personal lives and feeling interpersonally competent

This dialogue involved members of the group presenting interpersonal and intrapersonal encounters as a focus for inquiring into self and others. One member took the initiative early in this phase to present his story and talked about his life as being very positive and happy. The focus was on people who had influenced his thinking and he used my presentation as a starting point. The main focus of his presentation was not about incidents or emotive issues but more about people who gave him a philosophical or intellectual understanding of life and ways of coping.

GM - I did a lot of work looking at my life, starting at the last meeting. I used the back of an envelop while you were telling your story. [This statement is directed at me and I am not sure what to make of it.] In some ways I felt tricked, and in some ways not, because everything went out of my head when you began to talk about your life experiences. I was really impressed about what you were able to recall. It made me want to look at my own life. My life has not been negative or very emotionally demanding. I wrote quotes that I remembered others had said and what others have said about me. There are six key people in my life who have influenced me personally or through reading.

The speaker introduces the six people, and the focus is on the lives and writings of four gurus. The story begins at 18 years and the marriage break up at aged 25 is not seen as a significant event but as necessary for all concerned.

There was silence after this presentation for some time. I did not break this because I was struggling to gain a perspective on what had been presented.

GM - Some of those things I would have expected and some not at all. People are surprises when you get to know them.

This broke the silence and there was some surprise about the story starting at eighteen, and some comment about people feeling a little over-awed by the academic perspective and influence.

GM - I am feeling a bit overwhelmed by your knowledge, my reflections are all rather superficial. I am not familiar with all your references to philosophical readings.

GM - That is exactly how I felt last time - Everyone knows much more than I do. It was only after I did some reflecting that I realised - Yes I do!

GM - I felt that Neil's story was very high-powered and I have not thought of my life like that.

There is a temptation here to see a difference between how women and men present their life stories. The story just presented was a man's and the responses are from women. At this point I am inclined to say it is gendered in perspective. I will explore this in Part Three.

GM - That's exactly how I felt when I went away last time- "Oh my goodness every one knows so much more than me. Hearing you reflect on that I began to realise that maybe that is not true at all.

What does that mean for you Jane?

I had noticed that during the presentation this person had withdrawn and seemed to be engrossed in her own thoughts. I wanted to pursue the meaning of this silence.

GM - It was really just a flash that came through- 'This is all really high powered here, and I have never really thought and analysed myself in that depth. I couldn't relate it to my own emotions and feelings.

Isn't that something that we discussed last time about making sense of who you are through different pathways?

My aim was to encourage Jane to continue so that an acceptance of different ways of being could be affirmed. Jane continued to talk about her own experiences during the previous session and the emotions that were stirred as she recalled her own childhood where bereavement figured strongly,

Jane- I am amazed I am talking like this and not crying- for me it is a great step forward

Did you go away last time with those feelings?-- and was it all right for you?

Jane- Yes because I was consciously using reflection in a positive way, I wasn't thinking in a negative way . Like "I really do not want to think about this because it will give me pain." It was

more, "I really do want to think about this because I really do want to understand why I am who I am".

This introduced a new aspect of 'personal self' and it seemed that the research tools consciously used can facilitate self reflection that resolves internal distress. The issue or revisiting difficult experiences is pursued.

Jane- I listened to your enjoyable childhood (Neil) and I realised that I had an enjoyable childhood too. But my mother was very sick and therefore I did not have a teenage time, I was never able to rebel. The house was always welcoming and my mother was always long-suffering and a wonderful role model to me. My father was a very generous man who always cared for others. Both my parents died when I was young, before I married, and I missed them terribly. That is why I feel so much pain when I talk about loss, and that is why I felt so much pain when I left. It was not a problem for me it was much more a therapeutic thing.

GM - Revisiting events and revisiting the emotions is important.

Jane- You can revisit events and you can revisit feelings, and sometimes you can do this together. I find it too traumatic to revisit both the emotions and the events at the same time. I need to create a safe space to work through emotional memories.

This remark followed with a discussion about revisiting the past and rewriting it.

The next group member decided to present his professional self through critical incidents at work.

Colin - I can acknowledge that family influence me more, but what happens in my professional life reflects the things that have formed me as a nurse. Duty is important to me.

The focus of this presentation was on the nurses duty to manage the ward, not meet the needs of the patient, and if someone put the need of the patients first, then that raises the anxiety about what terrible things might happen.- This story was about how rules for safety prevented innovative things happening with patients. Safety was seen as paramount and the needs of patients very secondary.

Colin - Then one day I was assigned a very physically ill man to look after and I stayed with him all day. I learnt so much about nursing in that day, although it is quite possible that physically and mentally he had not changed. But for me that was real nursing and it gave me immense satisfaction. This gave me a different way of looking at the rules that make institutions 'safe' and prevent nurses from really being innovative and giving patients the care they need.

There were comments from others people about the difficulty in really responding to the needs of patients and being open about it. I noticed a recurring theme of not being able to say what nursing really was all about in the work situation where highly visible tasks are valued more than care and comfort. I struggled to respond effectively to the parallel text of

being challenged, taking risks and the competing meanings of the organisational demands and the internal demand to respond the needs of others.

As you painted those two scenarios I felt a sense of freedom. Some how the way you managed the situation allowed you to do more than you had thought you could do before.

Colin - Yes, I gradually learnt that nursing is really being with patients, I learnt that emotionally when I looked after this very ill cardiac patient.

GM - I think it is something about seeing the possibility and taking an opportunity to stretch the boundaries

This opened up the conflict that nurses experience when competing demands are operating and several scenarios are presented by others. The focus then went back to life stories that connected with being caught in a conflict situation.

GM - I would do anything to avoid conflict or personal discomfort. I moved from the ward because of a conflict situation, plus personal problems. It took all the fight out of me. I remember one of the consultants saying "You have either got to fight or leave." I felt "Yes, you are right, get out and go into something else." If I had been prepared to face up to things, and face the conflict, perhaps it could have been different, but anything that meant anger I avoided.------ My mother said that "People who are prone to an illness avoid conflict like you, you go to your room and read."- I wish I could say my childhood was fun. But I had a sister who completely ruled the house and I just retreated more and more. [This story continues and ends with the speaker deciding to be a nurse]

------I tried for a job and didn't get it, I really wanted it and I didn't get it. I had to get an job and nursing was the last resort.

I was aware of this persons personal health problem and my response was with this in mind as well as the ideas of accepting difference.

All of us have our limitations, although I have rewritten my own history and chosen to see it more positively, there have been times when I have not wanted to face things. It seems to me that your story about standing up for your friend when you visited her in hospital was <u>not</u> avoiding conflict but seeking to resolve a real painful issue.

This refers back to a story that was presented in one of the previous sessions.

That was different, I was fighting for someone else. I can do that, but when it is just me and something or someone else, then that is different.

Others added their voices to the difference between fighting for others and fighting for oneself . Again there was a connection between being a nurse and striving to met the needs of others, rather than being assertive about one's own knowledge and experience. The discussion moved on to revisiting and rewriting our past as a way of facing conflict now.

GM - I can relate to that. When I was eighteen or nineteen, I would have said that I had a very unhappy childhood, I was a twin and not the favourite. But now I have revisited it I interpret it differently.

I needed to affirm this stance because I believe that it (revisiting the past and rewriting our history) has the potential to liberate individuals and nursing. We move on to incidents at work and stories about relationships in the work context.

In this section I have focused on the research methodology and particularly the use of the audio-tape to record group interactions and stories about action and reflection in the work place. Critical incidents and revisiting the past, provided the focus for exploring personal experience. I have found it difficult to manage this data in a way that makes sense, and does not flow over into subsequent categories. May aim has been to highlight issues affecting group development and the way we manage ourselves at work.

Power and powerlessness in relationships

The presence of power and powerlessness in our relationship at work have been overtly or covertly referred to throughout the group work to date. In this knowledge seeking phase I intend to make overt what I believe has been covert and to highlight occasions where it was discussed openly.

Dialogue

GM - Something really bugged me at work. It was someone taking extra annual leave days, and because I have the responsibility to manage the teams and the allocation of leave, it was really important to me that it was fair to everyone.

Here is an issue where one nurse has power over other nurses and is finding some difficulty in asserting that power. It is presented in terms of being fair and not necessarily obeying rules.

GM - So it is about 'if you allow it to be go on unnoticed you have been unfair?'

GM - Yes it is something about everyone pulling together and not being selfish.

Is it about teamwork?

Here I test out another frame for managing this power relationship. It is one that I feel comfortable with because it does not exclude the responsible person from being part of the group. This leads into a discussion about the value of teamwork in nursing and being fair to everyone. Then the focus moved to developing and maintaining relationships.

GM - Just about all the relationships in organisations, including the health system, are artificial. We do not really know the people we work with because we do not chose to work with them. More often than not they are forced on us. We make no attempt to unravel where they are coming from.

This is the same agenda that was brought up previously the issue about 'togetherness'. I am interested to find out what the real issue is, I do not interrupt the flow of conversation.

GM - I do, [attempt to unravel people] I have to get to know people before I can work with them properly.

GM - It's much easier if you work in the lower level of the organisation because you have a smaller number of people to relate with on a fairly regular basis.

I consider-what research there is to inform this statement (the speaker is a man who values facts) I decide not to pursue this line but another.

But why don't you get to know the people you work with?

The response was about the complexity of the work and the number of people that "Do not really want to know you." I pursue it to test out whether there is a personal issue that is waiting to have 'air space'.

Who are the people that you would have the closest professional relationship with?

They are named and are the team that he is responsible for and other very senior nurses in the higher levels of the Health Authority.

So how do you 'unravel' them?

GM - That's the trouble it is so complex, it is impossible to unravel them all.

So do you make choices about who you spend time getting to know?

A vigorous discussion followed about who one can work with easily; and 'being caste into a role of working with some one that we have no affinity with.' There is a sense of being powerless to make a difference to the situation and feeling of being trapped. The discussion spreads to others giving their perspectives of how they have learnt to work with others.

GM - There are only certain people you can really get to know and therefore we need to be selective. We as nurses, seem to believe that we should be responsive to everyone to achieve what people want. To be effective we can only get close to a few people, because it takes so much emotional energy to be effective communicators.

There was then a discussion of the emotional 'bonding' in groups and what makes a close group of people. Leadership and the qualities of leadership that makes a team cohesive and the effect of the organisation on being open with others at work.

GM - If nurses can work together to create a little oasis that provides a sense of control, order and purpose then that is a positive development for nurses.

Discussion about power and the negative aspects of hierarchy followed this comment

GM - I have got one team where I am trying to be in a collegiate relationship with the members, and I am having incredible difficulties with some of the members of that team. They see themselves as autonomous practitioners and not answerable to anyone.

How do you use your power in that situation?

GM - Inappropriately often, I get bolshy, and that does not work. So now I have developed the negotiating mode. This means going very slowly and gradually, building up a way that works. I listen a lot.

So you are testing out ways of using your power?

---I think so, it seems to be working.

GM - If we are really going to develop more collegiate relationships, we need to try to put aside the hierarchy, it seems to encourages coercion rather than co-operation.

This led in to a discussion about personal experiences of being coerced and bullied into conforming in the past. The fear of being coercive to others was very present as we talked.

Inevitably when discussing the problems associated with power gained by status, relationships with doctors becomes an issue and as expected the focus turned to the power doctors have to influence the way nurses are able to work.

GM - It is always difficult working with doctors as colleagues.

GM - The expectation is that doctors will be controlling, insensitive and unresponsive to the needs of others, especially nurses.

GM - The difficulties centre around language and their pre-occupation with academic achievements. Even if they are female it does not make much difference. It is difficult for women in medicine to break the established role. They tend to join rather than question, and then they go 'off the handle' when a crisis occurs.

GM - They mostly retreat from conflict or 'follow the party line' and then feel bad about it.

It is funny how you know who you can trust and who you can take risks with. It is something about the way they (doctors) interact their language and their non-verbal messages. When you can break through the 'fog' sometimes there is a really genuine person . Then it is possible to have an equally reciprocal relationship. From my experience it is the nurse that has to do the work of opening up and developing trust.

GM - It is interesting that you should say that, I have just been in a meeting of 40 people - a primary care forum and the GPs were all down one side and us, the occupational therapists, speech therapists, and community nurse, down the other side. It was so interesting because the GPs were doing all the talking. I could see the chairman looking at all the nurses because they were saying nothing. Then the GPs drew people in. They actually wanted to know what

the nurses thought. That gave us all the confidence to speak out. But to begin with there was a real cultural difference.

This short scenario presents the situation where nurse and others allied to medicine are the largest professional group. Yet they will wait for the doctors to beckon them because it is too risky to guess where the doctors are coming from. The consequences of a wrong move are not clear. Even very senior nurses are careful about testing it. (Again chapter 12 will take up some of these issues. My own story will highlight some of the issues about differing cultures, trust, and speaking out.

Coherence and authenticity as measures of validity

Being aware of oneself and feeling that one is authentic in what one does has been something that I have struggled with. Allowing the questions to be asked when one feels very vulnerable is not easy, and paying attention to all the different levels of awareness required is equally demanding. Not everyone in the group talked about their own experiences in ways that spoke to a conscious awareness of coherence and authenticity. However, there were times when the intense questioning of actions, thoughts and feelings, could be 'read' in his way. The following dialogue has been selected because the level of questioning, or presentation, might indicate this awareness.

Dialogue

This dialogue begins with a discussion between two members about the way their careers have developed. They are male and female, I make this comment because this difference is one of the threads of the conversation.

GM - What sparked me off in your story, was when you said that you came into nursing late having had your family first. Where as I did it the other way round, I was nursing 10 years before I had a family. My children are six and four and I can date a certain loss of drive and interest in work to when my children were born. Although I did change my job, so that might be relevant. The colleagues that I went through training with were mostly women, and have taken time off to have their children. Most of them have worked part time, and have often suffered for their 'lack of commitment to the service'. I do wonder whether there is a link --'How much caring can you do as a human being?' For me there is just not enough to go round for family and work, given that caring is a big component of both. Is it actually reasonable to expect people with very young children to have that amount of caring left over for a full commitment to work? I do think that a lot of young women with children are criticised in the work arena for not paying attention to their careers. Or not really 'being there' at work.

GM - Or for just being a care taker?

GM - That's right for not having that drive that people without children do have.

Discussions about the stress of caring and the need to have breaks that help to 're-charge the batteries' is entered into by those with and without children. This was not just about the quality of work, but the expectations that nurses will be always there and always ready to put others first.

GM - I enjoyed going out to work for self esteem, the money, yes I needed that. I was in touch with nursing and the children got to know their father. Then when the children were nine and ten I began to see the possibilities.

GM - Exactly, you don't let the resentment grow, there is an end point when you will have more time. I can't have it both ways. I cannot have the salary and the advantage of mothers who can make the children the priority. It is not possible for me to take a job that is less demanding because we need the salary.[this is a man that shares the care of the children now that they are at school, there are issues of gender here that I recognise.]

GM - I never thought of a man being slowed down by having young children. I just thought they went on regardless.

GM - It is specifically the emotional bit about caring for people who are not particularly loveable. For example if one of my patients throws a temper tantrum, I have got one of those at home waiting for me. Where as five years ago I might have had the energy to deal with it better.

I was very attentive during this piece of dialogue and it seemed to me that those involved were beginning to be very open about their actions and the feelings that were a part of these actions. There was also a sense of noticing the possibility for misleading self or others. This thinking through and making the feeling connections is a part of managing the interplay between thought feeling and action in a coherent way.

GM - Is it something about expectations? Do we have very high expectations of ourselves?

GM - Yes I think we do, and I think it is because nurses historically has been predominantly female, and mostly unmarried. It's like the nursing role. It is not a role it is three or four roles and there has been so much caring needed, too much perhaps. Now things are changing and we have still got those standards to live up to.

GM - I think we are expected to be bottomless pits of compassion and energy. Quite often we do not know ourselves, what our limits are.

I hear this as a warning about ignoring our humanness in favour of being all things to all people. This way of being would work against coherent and authentic behaviour.

GM - Nurses have always managed, but now we are being asked to compromise our values about caring for people and being able to respond as is needed. If nurses are not able to make the decisions and manage the resources then patient care is compromised.

This conflict of making choices between the direct patient need and the needs of others is intertwined with women's work, because it is usually about responding to a complexity of demands, and working hard to keep everyone at least OK, if not happy. The conversation then moves to individual experiences of nursing. Ann talked about her childhood and being different from her peers. She illustrated this by presenting her feelings of guilt when she did not feel the emotion that others felt about death and dying, being different was in some way a threat to belonging to the group. Her way of coping was to pretend to feel as they did so that she was not left out. In discussing these experiences Ann came to the conclusion that her experiences of death as a young person made her more able to cope. This set her apart and now she feels she has come to terms with it.

We discussed the mythology about managing death, and recognised it was one of the 'initiating rights' into nursing. However we also recognised that it did not help young nurses to value their own thoughts and feelings and come to terms with the whole situation. This moved into another life story. This person talked about her struggle to be a nurse against her families wishes and how she finally succeeded after she had married and had two children.

GM - I would like to say that what you had to say was a marvellous way of opening up your life to us. I felt I had a stronger sense of knowing you when you talked of your personal struggles.

The things that you have been concerned about as a nurse, that I have known about, made more sense to me as you described them

Carol - I was saying in the car coming down, that I sat down with this piece of paper and I said "I will write everything down" and I wrote it all, and then I wrote "balderdash its all rubbish," and I threw it in the bin.[this refers to the life story]

GM - I think we feel uncomfortable when we find ourselves in focus.

Carol - That could well be but you think "Is it relevant to anything?"

But when you wrote down first of all it was relevant

I am concerned about the meaning behind the lack of confidence.

Carol - Oh yes, but I don't know whether I picked out points I wanted to focus on, or whether the points were just coming freely. It was very difficult to find which came first. [Here seems to be a concern for drawing out a 'true' story that is not contrived] But I have just kept quiet here because I feel I am really naive. I feel I have taken because I have listen and learnt a lot about people and how to cope with some of the issues I face at work, and I wonder what I have to give. I am very much in my infancy as far as nursing goes, I actually only started my training ten years ago.

This was the first time that this person had taken a central position in discussing an issue. This contribution made it clear to me to me that thinking. about being authentic and coherent in thought, feeling and action, is important to members of the group, but hard to locate in

discussions. It seems to be a case of searching inside oneself, and listening to the feedback from others, that brings this kind of coherence and authenticity into focus.

Interpretations and Reflections

Group developments

During this phase of the cycle there was a much easier flow of focus from feelings and ways of coping to tasks that required inquiry and exchange of ideas. The process for managing the task became more established. One person presented their personal story and included both content and feelings. Time was then given for reflection and sharing both personal professional concerns. This provided a springboard for sharing experiences and noting differences and similarities. I did not take a strong facilitative role as the process issues related to group cohesion and integration because they were managed by the group members. There were times when there was a struggle between a focus on propositional, intuitive and practical knowing (Heron 1981). The differences that surfaced were both about content and about whether feelings or academic prowess were valued more or less.

There were also acknowledge differences in our own personal stories and why we decided to take up nursing as a career. This was only made clear by the women in the group. My interactions within the group were most often part of the process rather than working towards a particular 'group' purpose. I felt quite confident that appropriate issues would emerge and my agenda was to contribute to this, make my own sense of it and inquire. The seeking of knowledge as a group activity was very available. However the inquiry did not challenge the way ideas were presented. A sense of respecting difference prevailed.

The research process

I did not chose to rigorously following cycles of action and reflection because issues and experiences were presented as part of the dialogue rather than each individual owning some space to present their experiences. The process was emergent and flowed across ideas and issues e.g. people tended to enter straight into explaining the experience with an initial internal dialogue and then to associate this experience with the thought feelings and actions. After this there tended to be a move towards the past, where this experience might be attached to. Or to the future and what they intended to do as a consequence.

The pathway to the issue, and the meaning for the person concerned, became apparent as the dialogue progressed. When it seemed appropriate I inquired into the process that had generated the ideas. Sometimes it was clear that action and reflection, had played a significant part in clearly identifying the experience and the understanding of it. More often than not I observed but did not question. To interject would have stopped the natural flow of ideas.

Some sense making occurred in a natural way as the process unfolded and members reflected on the recurring ideas and issues. I tended to provide reflections that I believed would be

most helpful for both the group as a whole and for individuals. e.g. 'People seem to arrive at a similar points in their lives, with all the skills to cope, having travelled along different pathways.' I paid some attention to the generation of ideas, experiences, and affirmed knowledge gained from practice.

I recorded my reflections after each session and paid attention to my own reflecting in action. In the text I have made some reflections available. These reflections have helped me to build up my sense making about the issues and the themes that seem to be emerging within the context of the group and practice setting.

My personal responses and actions

On reflection I realised that the development of our ability to key into each others ideas and keep an idea moving and developing, was more important at this stage than closely monitoring the use of the research tools. I came to realise that the first cycle of research introduced the method, and encouraged a familiarity with the tools through discussion and use. The next cycle of research should produce some reflections on the use of these tools and the ability to use the method in an authentic way.

Members (including myself) sought validation about seeing things differently and affirmed the need to revisit situations and 'truth seeking' from a different vantage point. This personal and professional interweaving of memories and experiences seemed to be liberating. We were all able to state our positions on an issue and relate it to situations that we were confronting and learning to handle. Most of my reflections about possibilities, and analysis, I did not bring into the group situation. .....opening up possibilities can be very confusing. I did not consider confusion to be useful at this time. There was enough difference and competition for the space and time available. I did not need to bring more diversity.

> Conflict arose in this phase around people not attending all the groups and not arriving on time. The question was raised about individual commitment to attend all the sessions. Again this issue was raised by the same member as the other challenges to leadership, to my style of facilitation and to the agreed goals. This time other members of the group took responsibility to provide a counter point to the statements made. "What happens when nurses are asked to make choices between attending meetings and responding to the needs of a distressed patient or relative?" This led into a discussion about how we, as nurses, manage the conflict between responding to the work demands and taking time to reflect, discuss, and exchange ideas with colleagues. I notice I have energy around not placing ultimatums on people if what is being asked of them is not congruent with the way in they chose to work. Particularly if it confronts their values in an inappropriate way. I also reflect that this is exactly how I experience being a nurse and is therefore not irrelevant to the purpose of this research.

The conflict that arose around the use of tape recorders, and the sharing of information with all members of the group, was an important issue and took some time to resolve. The anxiety

around this issue seemed to be related to confidentiality as well as the concern that people hearing may misconstrue what the speaker had in mind at the time. My reflections led me to link this concern to the need for nurses to maintain 'good relationships' with each other. Not to speaking ones mind avoids the risk of being misjudged. This fear is also about being isolated and unsupported when needs, or crises, arises.

There is something else that might be significant and that is about the 'silence of nursing'. It seems to me that this is not necessarily a negative quality but has some interesting concepts embedded in it. They are about the intimacy that is part of nursing practice and relationships that are based on that intimacy. However the cultural setting in which nursing is practised does not acknowledge the personal qualities of many of these relationships that sustain nursing. Perhaps intimacy can only be sustained where there is silence. My personal stories about nursing practice explore these idea and will be presented in Part Three where the themes of intimacy, and the cultures of caring and curing, were very much part of the stories I shared during the second research cycle .

Proposals for the final stage of the research cycle

At the end of this phase we summarised all the issues that had emerged and agreed that some issues kept recurring and held our attention, generating energy and feeling. These issues were about :

- The anxiety that arose out of using the research methodology;
- Managing our personal lives and feeling interpersonally competent;
- The genderedness of power relationships;
- Understanding coherence and authenticity as measures of validity.

We decided that these issues should go forward to the Sense making and Communication stage of the research cycle as beginning statements about themes and issues. We also decided that as the next group session would begin the process of finalising the first group the following purposes would provide the necessary focus for concluding the group and managing the transition to the second research cycle. These purposes were to:

- identify the issues and themes that emerged out of our work together and assess whether working together had provided a context in which we were able to share our work and improve our practice;
- decide whether we as a group or part of the group, intended to commit our energies to a second research cycle. If so how would we manage it?
- decide how we would close the group and communicate what we had achieved.

I sent these themes and issues as a summary to each group member together with my expectations for the final stage of the research cycle and group process.

Chapter Eight

Introduction

During this first cycle of research I transcribed the audio tapes, paying attention to my own role, and my own sense making at the time. I also established a pattern of writing summaries of decisions made at the end of each session, and sending these summaries to group members. My purpose was twofold, to provide a record for myself, and to encourage connections between one group session and the next. Before beginning this meaning making phase of the group, and sense making communicating stage of the research, I decided how I would approach the challenge of reaching consensus about the issues, and surfacing any unresolved conflicts. I also considered how I would facilitate the preparation for a further research cycle. I was aware that some members of the group were unable to be part of a further research cycle, however, I felt it was important to make these decisions openly with as many people present as possible.

I have a strong commitment to taking care of 'beginnings and endings', and I recognise this quality as both a strength and weakness. I know that sometimes it is easier for people to, 'just drift away' at the end of a joint activity. However, I work hard to ensure that separations are consciously taken, and any unfinished business resolved, as far as is possible. With some clarity about purpose, I decided to begin the first session by encouraging a review of our achievements, both individual and group, and to identify and agree the issues and themes. I knew that asking direct question of group members tends to elicit minimal responses, therefore I needed to generate a dialogue to explore way we worked together. The actual process that emerged during this phase, was not as I expected, as a consequence managing the transition between one group ending, and the new group forming, was very difficult.

I realised that I, as well as others, had unfinished business. For me this was not fully resolved until I revisit this first cycle of research and gained another point of view. This stage of the group cycle became thoroughly enmeshed in the group process, therefore I have decided to present each group session separately. This will provide some clarity about how the themes and issues emerged, how we managed the challenge to the methodology, and how we agreed the purpose of the second research cycle.

The Meaning Making Phase

This stage of the research cycle took three sessions, and was spread over two months. In terms of group process, it provided the catalyst for all the loosely held ideas, experiences, understandings and discomforts, to come to the surface and seek resolution. In this phase of the group work I have decided to present each group session separately. This is because each session held a particular focus and although the ultimate purpose was to complete the cycle of research and close the first group, the challenges facing each group were different.

The first group session focused on the agreed purpose of, sharing the meaning we made of our experiences, and communicating this sense making to each other. The intention of the second group session was to continue the process of agreeing issues and themes, and then decide the development of the second research cycle. However, instead of moving smoothly from one session to the next, conflict emerged about the methodology and the identity of nursing. This conflict needed to be confronted and resolved, before any decisions about future possibilities could be taken. The final session moved back to the original purpose, focusing on the issues contained in the conflict, and the membership and development of the second research cycle.

The first group session

Seven members of the group attended this session, and we began by reviewing the themes and issues that were summarised at the end of the 'Knowledge Seeking Phase'. These were:

- Anxiety that arose out of using the research methodology
- Personal lives and feeling interpersonally competent
- The genderedness of power relationships
- Coherence and authenticity as measures of validity

This review acted as a focal point for discussing the issues that were 'alive' for group members. From this debate two key concerns were identified:

- our ability to support and inquire of each other within the context of the group;
- our ability to discuss and improve our use of action and reflection in the workplace.

These concerns were then expanded in terms of the issues that they contained, using personal experience as the data. We then agreed that the issues that either enhanced or hindered were:

- Group acceptance and affirmation
- Personal and professional experiences
- Uncertainty and impossible tasks
- Not being heard
- Power and powerlessness
- Role conflict and confusion

To provide some substance to this process of identifying issues, I will present extracts from the dialogue using the above headings. At the end of this process I will record the agreed themes.

DIALOGUE

I will use the same criteria for identifying *[my voice]* [my comments], and the voices of other members of the group ,as in the previous chapters.

Group acceptance and affirmation

I opened up the dialogue by suggesting that we focus first on being part of a support group, where the intention was to learn together, and become more confident and able at work. I invited people to express what ever came to mind.

GM - I found it difficult to contribute at the beginning of the group, I think I needed to know more about what to expect. What I will have to do?

GM - I have emotional reactions that I have no hope of predicting or controlling so I needed to know that the group was willing to accept this before I could risk it.

Did you get that clear as the group progressed.

GM - It was quite complicated really, I knew that emotions were accepted quite early on but it depended who was present whether I let people know how I was feeling.

I did not pursue this point because this is not unusual in beginning groups. and I wanted to get others points of view. I also thought that we could easily slip into the group support mode and it was important to me that we focus on evaluation,

GM - I did not have as much group experience as others but I found that I did share some of the feelings and experiences that were expressed, although I did not always say so. It is much easier to talk about it now. Now I feel I could really get down to business.

GM - It has been difficult for me too, I need time. A lot of things we discussed I felt I shared-I would like to be able to talk about myself more. I feel that it is really good that this is going on. I am very positive about going on now.

This affirmed my own thinking that we have really only reached first base, it is from this point on that the potential for a deeper understanding of each other will emerge.

GM - There are many things we do not know about each other, but we cannot know everything about each other unless we chose to disclose it.

GM - Yes, I felt quite neutral to begin with, as I understood more about what we were doing so I felt much closer. I still feel that people who knew each other before the group are much closer and got more out of it.

This is a question that I have had about support groups- 'Are they best developed within a work context or where all are newcomers?' or 'Should there be a nucleus of people who have group skills and can guide the process so that the facilitator is not so separate from the other members?'

GM - The most important thing for me is how different we all are.

This remark leads to a conversation about the need to have difference especially with regard to work context and personal experiences.

GM - Sometimes I want to ask or contribute, but often I didn't because it might not have been appropriate

GM - I am still anxious about confrontation, although I know that resolution of conflict can bring closeness. But sometimes it doesn't, it, just feels unresolved and hurtful.

[This echoes for me the unresolved conflict that I have felt bubbling up at times and that I know I need to surface before the group ends]

[When I asked the speaker what happened for her that was difficult. She refers back to time where she talked about her work situation and how difficult this was to revisit and talk about. she concludes with—]

GM - this is something new for me, now I will feel more comfortable if a similar situation occurred

GM - yes but you have got to accept that people may feel uncomfortable with revisiting and re-interpreting events especially if there has been unresolved conflict.

GM - It is the feedback that helped me to understand about the way I coped, or didn't cope, with the things that are happening at work.

There is affirmation that sharing ideas and experiences together is very important, even if we cannot explain in terms of actual things we have done.

GM - Being together is really important and although I tried to attend all the groups, I still missed one session. Other duties do encroach on personal needs.

There were other comments that referred to the group as being something that was personal and met the individual's needs.

GM - Sharing is the most useful part for me, even when I said nothing I was still sharing experiences.

The value of the group was expressed in very positive terms. The membership of the group was questioned, and the position such a group has, with reference to competing demands on the individual's time. The management of conflict in the work place was also an issue that was not necessarily addressed. However, the support in the group did allow people to surface painful issues, and feel that they had resolved them, Sometimes finding better ways to cope.

Personal and professional experiences

The focus on personal experience began with the following comment

GM - I was really amazed the other day when I read in one of he nursing journals that 'nursing is about the use of self as a tool', and I thought thank goodness someone has come out and said what nursing is really about.

This comment sparked a discussion about what this implied in the statement 'use of self as a tool' the need for good interpersonal skills. our understanding as nurses about patients needs are seen as key to this. It also brought up issues of power between nurses and patients, and being able to develop an equality of relationship with patients and colleagues. This moved again into the differences in the way nurses manage relationships at work, intimacy was inferred but not discussed.

GM - If we are going to use ourselves in relationship then it is personal as well as professional, how do we keep the boundaries and act professionally?

The validity of seeing things differently was discussed and the notion that parts of what we do are particular to that situation and private.

GM----some things cannot be discussed with people who work differently, like doctors and managers.

GM - I am employed as a nurse manager but when I work with bereaved relatives or distressed members of staff, I would not discuss it with others, it is confidential.

GM - Would you discuss it with us?

GM - Yes, now I would, unless I was breaking someone else's confidence. If people 'bare their soul' to you , you don't want to tell someone else. I might talk about my own feelings and the way I coped though.

[There followed a discussion about needing to inform others when it is in the interest of the person who is distressed and, who would need to know. This led into 'having a voice' and risking 'speaking out.']

Not being heard

GM - the question is what do we, or don't we, reveal? Is this culturally bound, these feelings of taboo in nursing?

There is something there for me about not having the language to explain the process of caring. I think it is related to gender and women's work not being valued.

The focus then moves to considering what we brought to this group to discuss.

GM I had to test out first what was OK to talk about

GM - I remember Neil saying that he could not talk about work based incidents because they were mostly with people higher up the hierarchy than us

GM - That means that the hierarchy in nursing stops us being open about what is happening at work.

The idea that the hierarchy might silence the voices of nursing is explored.

GM - There are some people in the hierarchy that I would talk to quite openly.

GM - I would not go to my boss, I find her very authoritarian. I would go to other people at the same level.

So is it about position, personality, or about having the time to really know people?

GM - I think it is a bit of each, but it hinges on people being able to understand from another point of view, and 'Hearing it as it is', without judging.

GM - It really is important this thing about being able to use ourselves, because if we cannot think and act this way, how can we support our staff in developing these skills?

GM - Bosses don't reveal themselves, it is seen as a weakness by other people like doctors- once you have, it is easier.

This led to considering an environment that–'allows real dialogue to develop.'

GM - Creating an environment also means having space and time.

GM - Being busy does not necessarily keep people away. Sometimes the busiest people make time for the unexpected

Time does have an influence in the depth of our relationships, boundaries must be open but that requires time and energy to create and maintain.

Uncertainty and impossible tasks

GM - I feel very anxious when I am in situations where I am not sure that things are going to turn out right. I feel it is good when they do, but there is anxiety and apprehension until it works through.

This comment is followed by a very active discussion about anxiety provoking situations and each speaker presents a scenario from past experiences

GM - It is very confusing the way nursing is changing, education, management, the health service, but when you think about nursing we have always had to adjust to other people's ideas. I suppose that is why we try and concentrate on nursing care rather than organisations.

GM - It is the case that the structures are becoming more rigid in education and more dependent on ticking boxes in the clinical areas. I think both these changes work against innovation.

GM - I think it is something to do with energy gaps, we need energy gaps to face particular issues. Picking it up and following through is not easy, there is too much routine to be taken care of.

This last comment was in relationship to finding the energy for noticing opportunities and following them through. A profound statement followed.

GM - Nursing is about uncertainty not rediscovery metamorphosis, inside there is something waiting to unfold, there is an energy for this, we can unleash it if we put our energies together.

Nursing is ready and we need to be ready ourselves because we represent much that is nursing.

GM - Thinking about the future and where we are going, and what we are valuing, makes the past seem bad. I think we should value the past.

GM - The goal posts keep changing and we need a different set of skills and knowledge, it is impossible to know the future - we have to prioritise and sometimes we get it wrong

GM - I think we just need to keep everyone going in the same direction, and when the goal posts move, everyone moves together.

We collapse in laughter and this brakes the urgency and emerging feelings of powerlessness. I made a comment and suggested that we focus on power and powerlessness as an issue.

Power and powerlessness

GM - I think real power is about leadership and I like to think real leadership applauds others skills and seeks out others that can contribute in a different ways. Encourages innovativeness and creativity-

GM - How do you encourage innovativeness and creativity when there are very rigid rules?

GM - The Department of Health Care Studies gives room to be creative with in the teaching modules, but relies on a leader who can play the rules and tolerate uncertainty. This can be very difficult if you believe that a manager needs to know everything that is going on.

GM - Power is an issue for me because I get caught believing that some power is good and some is bad -we don't use our power well, we often reject it, and that means rejecting independence.

GM - That means that power supports autonomy versus dependence?

GM - There is something about power being good or bad, and I am thinking that it is about gender because nurses often get accused of manipulating or coercing patients

GM - That's because people outside the situation do not know what is really happening, sometimes we have to use our powers of persuasion to get people to do things that might be very uncomfortable and frightening.

GM - Perhaps we do have to pay attention to how we do that, there is something about including the patient in the decisions and shifting power to the person who is affected the most.

GM - That can be about how we manage our teams and people who are responsible to us.

GM - It is not so easy with colleagues because we rarely have control of the situation.

Don't we? I think we have more control over the situation than we acknowledge, other disciplines rely on us to get the work done.

Role conflict and confusion

GM I do not think the changes in professional nursing have ever been accepted, people still value tasks more than the way care is given.

GM. I agree, nursing is therapeutic, not just mechanistic tasks.

These comments start a discussion about the conflicting role demands that are made on nurses from the profession, from the general public and from the work context.

GM - As ward sisters, we are involved in contracting where the viability of the nursing care is at stake and we are politically bombarded with a different culture. I was trained for nursing, and most nurses do want to be involved in decision that affect nursing, but sometimes it is difficult to see the connection.

GM - It [political demands] undervalues what nursing is all about, and it also undermines good quality care.

GM - Nursing has gone through a culture change, and we have affirmed a more scientific way of presenting nursing. We have made clear the dependency levels and the staffing needs to give quality care, but this has not been affirmed by others. They are still seeing the tasks to be done and they don't want to hear about any obstacles.

GM - Nurses have always managed, but now we are being asked to compromise our values.
Gm - Nurses are given extended roles but other professions do not get the information- doctors are still seen by the public as being the centre of all health care.

We return once again to the relationship between nurse and doctors and the way nurses fill the gap when new work is created by doctors, administrators, and other health workers.

Searching for themes and patterns

At the end of the group session we pulled together the issues and considered whether themes had emerged across the issues. We used a round of statements to do this.

GM - Some of what we have talked about is similar to conversations at work, emotions and power and conflict. I have thought a lot about what nursing really is, and the power that nurses have. How they use it, or do not use it, is really important to our future.

GM - Working together is important -looking at choices and getting feedback-setting time limits and being sure that people have time to open up and develop and gain closure.

GM - The question sometimes is about what to target, goals, work situations, personal experiences, or just managing to cope with everyday crises.

GM - There is a connection between our personal and our professional lives critical incidents at work are separate from our personal life, but personal attributes are not separate from how we manage those incidents.

GM - Conflict about our own expectations and those of others finding the power in our own role and the weakness we feel about challenging others are the issues that are important to me.

GM - Making sense of changes that are ongoing and valuing the past and the future are very difficult to balance. I feel very responsible when I see young inexperienced nurses overwhelmed by the speed of change and the insecurity.

Agreeing a way Forward

From this set of statements we agreed what we thought were the themes and we then discussed the way forward. The process of defining and identifying themes from issues was very muddly and I considered that it was not important at this point. What was important was a consensus of opinion that would hold for the present, and could be revisited in the future. I offered to send a copy of the results of our work together, a copy of the research methodology and the validity measures, and a note asking for ideas or comments before the next meeting. The themes that we agreed were:

- The tension between our professional and personal selves.
- The way in which we do or don't express our needs as nurses and people.
- The characteristics of nursing that are shared across the different fields of nursing.
- The organisational and political issues that affect nursing and influence practice.
- Ways we have learnt and need to learn about working together as peers.

At the end of this group session I sent each member a copy of the agreed themes and the issues that were associated with each theme. I also enclosed a summary of the research methodologies [Rowan and Reason] and the validity criteria [Heron] discussed at the beginning of the first cycle of research.

(At this point it is important to add, that my analysis of the issues and themes changed as I moved through the second research cycle, and as I became engaged in writing the research text.)

However, while working as a group member, and focusing on the completion of the first research cycle, my attention was on listening to my peers and responding to their sense making, as well as my own. It was clear to me as we reflected on the group process and the research activity, that this sense making phase was also about disengaging. As group members review their experiences and made decisions about their careers I felt a sense of closure. The question of moving on to a second cycle of research encouraged a much more critical approach to the work we had achieved, and time was spent on the issues and themes that had emerged and had influenced personal practice. This concentrated work helped choices to be made and provided the clarity needed to plan the next research cycle.

The Second Group Session

The recurring conflicts presented in the first part of this chapter, came to fruition as we revisited the research purpose and methodology. This challenged the groups viability, and through

conflict and declared differences, brought about an overt commitment by some members to the second cycle of research, and allowed others to leave. The process of resolving differences set the purpose for the second cycle, and affirmed a more practise centred approach to action, reflection, and inquiry. I took a strong lead in managing the transition between the two cycles of research, ensuring that the issues that emerged during the process, were resolved and that people worked together to reach agreement.

I came to this phase of the group process, knowing that I needed to address any unresolved conflict. I suspected that any conflict may not be entirely centred in the group, but part of other situations and relationships in the past. I took some time to reflect on the patterns and themes that I had observed, in order to predict the possible unfolding of group process. I decided to focus on being authentic, honest and straight, and work with whatever emerged. I also decided that although I had taken a facilitator role throughout the research cycle, I shared with my peers the sense making process, and the planning for the next cycle .

This second session, although well planned in terms of preparation for consensus and closure, provided the focus for the conflict to erupt. This conflict placed me in a position where I had to take a strong leadership role in order to manage the attack by one member on the methodology, and the rationale for peer group support and appraisal. This attack felt very personal, and from this perspective I felt undermined. However, because the attack was on the research methodology, and in particular the relationship between the research tools and nursing, I also felt that the contributions of others were being de-valued. In this I felt very angry and my tolerance to difference plummeted, ironically, this gave me the energy to take control and manage the conflict..

I have revisited this experience with my colleagues, and although we see the process and the key issues in a similar way, we all have our own analyses of it. My understanding now is that each of us who participated in that second session processed the event from a personal point of view, and came out a little wiser.

Managing conflict and all that it might mean

This second session began with a review the research methodology, and the validity criteria, and to stimulate discussion and focus attention I prepared two overhead slides outlining the key points . The first focused on 'the early stages of a co-operative inquiry', requiring participants to discuss and agree what ideas and theories they bring to the inquiry, and what kind of research action they wish to undertake to explore these ideas.(Reason 1981) The second referred to validity:

> "A major validity requirement for this type of research is that participants be committed to the ideas which they then explore as a whole person, in practice or experience, becoming deeply involved in that experience at the same time paying attention to what is happening, and how the original idea or theory enhances and informs the

> experience, or alternatively distorts or omits important aspects of the experience."(Heron 1988)

I invited comment and the dialogue began with Neil challenging the research methods. He used rather a scoffing tone and talked as if he had not been part of the first two groups where the methodology and research tools were thoroughly discussed and compared to the 'nursing process'. I found it very difficult to bring other members of the group into the discussion and found myself defending the use of the research methods and tools.

I avoided challenging him about being part of the original agreement and that being part of the research was to work within the methodology. Intuitively I felt to confront this issue 'head on' would be to miss something. I was conscious of entering into a prolonged dialogue but found it difficult to include others in what was essentially a challenge addressed at me. However as I reflected in action I was able to focus on another 'truth', that I was the focus only as facilitator and leader for the research cycle, not as co-subject.

This idea enabled me to centre myself and pay more attention to the non-verbal communications of other members of the group. I then felt able to draw back from the interaction, allowing others to take the lead. The pattern then changed and each member of the group took a lead role, giving their particular point of view about the use of the research tools and the methodology. Each tried to explain it in terms of nursing and their own experiences. The dialogue continued to take place almost entirely between Neil and one other person, and each person struggled to find a way through the conflict to common ground.

I found it impossible to shift the focus to the task of seeking agreement about the issues and themes, and planning for the next cycle of research. On the one hand I felt that Neil had 'high jacked' the meeting, and on the other hand I was fascinated by the lengths we were all prepared to go to achieve some mutual ground. I allowed the dialogue to continue with Neil as the focus for some time, and then I decided to confront the purpose of the session overtly. I mention time, and purpose, and asked for agreement about the task for the meeting, given the short time left. I did not choose to reflect on the process because others were probing process issues. My intervention came from the position that the dialogue was avoiding commitment to the next cycle.

I waited for the tension to reduce and then I restated the agreed tasks, and asked each member whether they wished to return to this agenda or decide otherwise. Each gave their point of view about the issues that had been raised on the papers I had sent them. They also stated their position about a commitment to the second research cycle. I ended the session by paraphrasing each person's response to my question, and made it clear that I did not want to encourage anyone to be part of the next research cycle unless they felt able to fully participate in the methods.

Neil stated that the methodology was flawed and far too complex and academic, and that action and reflection and keeping reflective diaries should not be a part of nursing. This completely silenced the rest of the group, and I refrained from getting into further arguments by re-iterating that a willingness to work with the methodology was a criteria for group membership. He affirmed that unless the whole group discussed it, and examined its credibility, he could not be part of a further research cycle. This heated discussion took up some considerable time and we were unable to talk through the issues, or the way in which we wanted to conduct the next research cycle. We agreed to meet again to plan for the second research cycle and I agreed to write to everyone with a further summary and a meeting date.

At the end of this meeting I was exhausted. I had insisted on a clear statement from Neil, because I believed I would lose other members of the group if this 'bubbling' conflict was not resolved. Working through this conflict had raised issues of validity and authenticity for me, and left me with work to do before the next meeting. I was aware that conflict that continually 'bubbles', and is so obviously ignore, has aspects to it that are not readily apparent within the presenting context. I realised that this would take time to resolve, and I needed to get some distance before I could hope to be rational about it.

I decided to leave the question about:- "Who owned the conflict?" and "Where did it belong?" to a later date. I realised I needed all my energy and clarity of thinking to cope with the immediate issues of closing the first cycle of research and agreeing a plan for the second. I began this process by contacting all the group members to ascertain their commitment to the next research cycle. Once this was achieved I wrote to all group members who had given a commitment to the next research cycle as follows:

> I am writing once more because I have contacted Jo, Geoff and Ann and now need to give you some feedback.
>
> Jo is not sure whether she can commit herself to the next cycle as she is immersed in her own PhD and not sure of her availability. Ann is not able to attend on the 6th as she is working a late shift and Geoff is not able to manage the commitment but would like to remain in touch and contribute at some time during the cycle (us to arrange).
>
> As I mentioned in the last letter I have received a letter from Neil withdrawing from the group, what I did not mention was that I had sent a letter to him and that our letters passed in the post . Since then I have received another letter from him and I now enclose all three of these letters because there are comments that do not just relate to the kind of research we are developing and my style of facilitation. The group process and the thoughts and feelings of the members are also an issue for him.
>
> I would like your ideas about whether the issues that Neil raises and the comments made are your concerns also and need some 'air space' at the next group. I am very willing to discuss

what ever you feel is needed but I am equally willing to focus on the next cycle and the ways in which we will work together to achieve all our goals.

The responses I had from this letter encouraged me to plan the final group session with the aim of achieving the following tasks:

- *decide whether we wished to respond to Neil's challenging letter as a group;*
- *clarify the issues and themes that had emerged out of the research;*
- *agree the group process and research focus for the second research cycle.*

In preparing for this final group session I revisited the themes and issues that had been agreed at various points during the research process so far, and I planned my own research focus for the second research cycle.

The Final Group Session

This session began with a commitment from all the members present to resolve the conflict that centred on the research methodology and the management of group process. I stated the concern and confusion I personally experienced when I reflected on the way the conflict had emerged and gained focus. I also made clear my intentions of revisiting my understandings of the conflict as part of my own research. I then invited each person to express their own feelings or thoughts about the conflict as a way of beginning the process of resolution. This led quite smoothly into a dialogue about the ways in which the issues raised by Neil might be satisfied. Decisions emerged as a consequence of this discussion are contained within the following dialogue.

(As in previous dialogue my voice is in *[italics],* group members [GM] in [body text])

Dialogue

GM - That is typically Neil when we really need to expose our vulnerabilities and support each other Neil is not there. I do not want to keep going over intellectual ideas I want to be able to find real solutions to the difficulties I am facing.

GM - I am quite certain that if we continued going backwards like the last meeting, then I would not want to be part of it.

GM - I think that we need to agree what we are going to do and then get on with the research, I do not want to spend time on it. Neil was never really committed he has always made an intellectual exercise of the issues that we discussed.

GM - I think it is hard for some people to say that they are not really able to take part, for what ever reason. Especially if you are in a position where you believe that you should be the authority

GM - What I would like to say is that Neil has always challenged your leadership and this is just something that was waiting to happen.

GM - I feel very uncomfortable about it all because I admire Neil, he has always been very supportive to me. But I can see that he has not really committed himself to this group he was always pushing in another direction.

GM - I must say that often I would think 'for goodness sake Neil shut up and let some one else say something' now I wish that we could find a way of keeping him in the group, it seems a bit like we haven't tried hard enough.

GM - I can agree with some of what you have said, but I think that if we keep on agonising over what we might have done we are guilty of not getting on with the real work, of being part of this as a research group that perhaps makes us vulnerable too.

GM - Well I think that now that the conflict has come to a head I will find it easier to be vulnerable and bring some of the real issues that are troubling me to the group.

So what will help us take the next step and finalise the first cycle and begin the next.
GM - We could just get on with it and accept that some people leave a group with difficulty,

You mean not respond to Neil's last letter
GM - Well you could respond from your own point of view
I would prefer to do it in an open way with some agreement within the group about what would be most helpful

Gm - Your could just say that we are moving on to the next cycle and sorry he has decided to not be part of it

GM - I think you should say more than that because he has really challenged you.
What if I responded to his challenges about the methodology, the purpose of the research and the validity of using our own practise in whatever setting that might be.
GM - That would be a good idea and then we would be clear about what we are going to do in the next cycles

---

This discussion was difficult for all of us and I could sense that some people would have preferred not have taken part. I could understand this, and at times I was tempted to take full responsibility, however I held on to the core belief that as the conflict had arisen within the group, it belonged to us all. I believed that to resolve it as a group was something we needed to do in order to move forward and cope with conflict in the future. However having agreed the intervention needed to resolve the conflict with Neil, we then proceeded to discuss some of the issues he had raised. The discussion flowed over the three issues of: managing the group sessions; the role of facilitator; and Co-operative Inquiry as a methodology. I will now briefly present the discussions we had and the decisions we made.

In discussing the way inquiry had already developed as an important aspect of our work together, it became clear that the process of reflection and action was a key part to the inquiry process. This being so, we decided that a Co-operative Inquiry methodology was compatible

with our research intentions, and would provide the framework for exploring our experiences. We then discussed more fully how we would manage the group process and considered sharing the role of facilitator or, having none at all. We concluded that the role of facilitator was best shared amongst us so that all members including me would be able to focus on their own agendas as the need arose. Within this context the use of the tape recorder was considered unnecessary because each of us agreed to keep a reflective diary. These diaries would be used to record experiences of researching in our own work setting, and reflecting on the group process. Therefore they would be a resource for sharing our experiences and commenting on the group process.

In considering the most useful ways of managing group time, we decided it was important for everyone to express whatever was uppermost in their minds at the beginning and ending of each group, thus allowing the remaining group time to be allocated to one or two people. This allocation of time, we believed, would encourage inquiry, feedback, and a sharing of ideas about the presenting issues, and would provide a space for group process feedback. Having agreed how we intended to manage both the group and the research process, we then turned to the task of sharing our understandings of the themes and issues that had emerged within the first cycle.

We began by recalling the themes and issues identified during this final sense-making phase. This led us into an intense discussion about the way in which themes and issues changed according to who was present in the group, and what was happening in one's life. At this point I became aware that passions, fears and personal doubts were being surfaced as each person contributed their understandings about being a nurse, and a group member. To interrupt this energy by promoting a wider context for understanding experiences, and abstractions, would have lost the intensity. Consequently, regardless of the intentions of agreeing issues and themes, we arrived at a series of understandings about our work and relationships, that seemed to hold meaning for all of us.

From my point of view these understandings reflected some of the themes and issues that had been discussed in the past, and are therefore coherent with the task of sense making. My intention at this point in the process of closing this first cycle, was to arrive at a collective understanding about what had emerged, and was important to take forward. I was fully aware that collective understandings can never be complete, however if they hold meaning at the intellectual and feeling levels for the people concerned, it is sufficient to create the pause needed to move on. *(On reflection I realise that these agreed statements set the scene for the stories that emerged in the second cycle.)*

To give the reader an understanding of what was agreed, and therefore what was taken forward into the second cycle, I now include these statements as they were agreed at the time.

- Caring is fundamental to nursing;
- The conflict between market values and caring values is stressful;

- Each of us brings a different contribution to peer group work;
- Experiences about being a nurse and nursing are very similar amongst us;
- Role conflict is present in all the contexts where we practise nursing;
- Feelings of duty, guilt and powerlessness are present for us all;
- Peer support and openness is necessary for self validation;
- It is important to learn to manage challenge and conflict;
- Managing multiple tasks and agendas is a 'balancing act' and a part of nursing;
- Coping with both pain and affirmation, are a part of being a nurse.

Having addressed the task of acknowledging the issues and themes that emerged during the first research cycle, I then opened up the task of agreeing research intentions for the second cycle. This was taken up with enthusiasm and each person presented their own intentions and invited inquiry.

As the different intentions were presented I was struck by the repetition of certain issues (interpersonal competence, role clarity, team work, the nature of nursing, authority and responsibility). However I did not comment because I believed it would be in the actually experiencing the research process, and the telling of that experience, that the themes would become transparent if they were, in truth, important.

To set the scene for this second research cycle I will present each person's intentions as they states them -

> I am aware as I write that these intentions were more about discovering personal skills and abilities than actually researching nursing per se, however we decided that understanding nursing is about understanding what nurses do. This cycle of research is about paying rigorous attention to particular aspects of our practice.

(Each person is given a pseudonym.)

Colin Write a paper based on critical clinical incidents to explain nursing. "This will involve direct nursing experiences within a clinic for homeless people with drug addictions. The process will be to record the incidents as they happen through team discussion with the intention of developing innovative practices. I will also reflect on my own interventions as a team leader."

Mary Focus on interpersonal relationships and team building by reflecting on my own personal process and interventions. "I will also reflect with the team as interactions occur with the aim of encouraging positive interpersonal skills."

Jane Focus on taking up the challenges of working with other disciplines as well as nurses. "I will need to be encouraged to reflect on my decisions so that I can develop a framework to cope with the challenges. To test it out on 'impossible situations' and critical decision making would be the ultimate goal."

Linda Focus on personal role change by considering my professional interactions with different people. " will work towards planning for the change by sorting through the variety of interpersonal situations that might be important to future choices. This is mainly a personal process."

Eve Focus on conflict that affects my role and the lack of personal power to influence the situation at work. I intend to observe myself and others and wait for the timing.

Clare Focus on the conflict between real and ideal role leading to the possibility of personal and interpersonal conflict. This will involve keeping the balance between research with students and both personal and teaching roles within a climate of radical change where some appear to be losers.

Sara Focus on being authentic and affirmed in my role as a nurse through identifying situations that are both negative and positive and by observing and keeping a diary to reflect on the possibilities for change. "The aim is to find out whether my work place and in particular my boss, can support me as a nurse or whether I need to find another job."

Me Focus on the role of nursing in a changing environment through significant role relationships between nurses and other disciplines. "This will involve paying attention to particular relationships and how I cope with different perspectives and different role expectations. I will use the tools of action, reflection and inquiry to better understand my role as nurse, and how I can best interact with others to encourage a climate of inquiry. I will also pay attention to the cultural context as I focus on particular relationships."

Having made our intentions clear, and agreed when, and where, we would meet to begin the second cycle, I was left with the tasks of recording the results, and writing the letter to Neil. As I began to tackle these agreed tasks, I realised that the process of answering Neil's doubts had served two important agendas, each aiding the transition form one research cycle to the next. Firstly our sense making about both the content and the process of the first cycle was sharpened as we considered different points of view, secondly the discussions that we entered into provided an underpinning for exploring and agreeing our intentions for further inquiry.

> Now I am aware that this shifted the research focus to individual inquiry and interpersonal development

At the time of writing the letter to Neil I realised that the issues he raised, and the agreements we reached in response to them, created clearer understanding between us about how we would manage the second research cycle. The personal research intentions and the collective commitment to use a Co-operative Inquiry methodology was achieved within this context of challenge. Therefore my letter to Neil contained the following agreements about the second research cycle.

- *The research methodology is satisfactory and we would prefer to use it rather than discuss it any more*
- *It is important to bring actual nursing work to the group so that the discussions have life and meaning for nursing*
- *We are committed to identify a part of our work as a focus for research and intend to practice both reflection in action, and reflection for action, as tools of inquiry.*
- *We have agreed to meet for six more sessions and each session will involve time for members to reflect with the group, time for reflection on the group process, and planned time for individuals who wish to present their own personal experiences.*
- *We have agreed to allow time to work through conflict , encourage feed back, share facilitation and ensure that time is given to both the process and the structure of the group (process being how we support and encourage each other and structure being the agreed way in which we structure time and move from one activity to another).*

This letter ended my communications with Neil, although I was pressed by some of his staff to talk to him as he was still 'hurting' and because he was, "having a very difficult time and 'falling out' with people he should be working with".

The nurse in me felt the pull to 'be available' but I considered that this would not be helpful and that some space was needed before we could interact in an equal way. The time came quite unexpectedly about six months after this encounter. I had responded to a request that I join a group who were working through the place of spirituality and spiritual needs in nursing, I found myself in a group with Neil discussing my beliefs about spirituality! We had a very agreeable time!

Reflections and Interpretations

I began the first cycle of research intending to manage the group, and the research process with rigour. To achieve this I set myself somewhat apart from my peers because my role as facilitator/leader and 'keeper of the records' gave me an added responsibility. Rarely did I contribute my experiences as a focus for discussion. My role was more about setting a climate for inquiry, encouraging risk taking, and finally drawing ideas together to test out agreements. My personal learning was about the complexity and the energy needed to manage competing agendas, and how best to cope within the research group and in the work place. [This mirroring of complex agendas is part of my own research in the second cycle].

My energy as I participated was towards highlighting possibilities thus allowing different interpretations to be made. At the conclusion of this first cycle of research I felt confident that the agenda both individual and collective for the second cycle was clear, and we were in agreement about how we would manage the group sessions. I considered that taking less responsibility for managing and organising the groups would allow freedom to listen, inquire, and contribute my own research experiences. This freedom from responsibility, and the

challenge to make sense of the research data became the 'horns of a dilemma' as I struggled to write a research account of the second cycle

A Pathway To The Second Research Cycle

It is necessary to pause at this point and explore the nature of my dilemma as it was instrumental in shifting the focus from cycles of action and reflection, to story telling as a way of recounting and understanding experience. It would be reasonable to believe that as we paid much attention to how we intended to manage this second cycle, and what we intended to do, both individually and collectively, writing the research text would be a simple matter. Not so. The very nature of the planning, and the commitments we made to work together in a supportive and inquiring way, proved a real challenge to me.

The reality was that each person chose how and when they contributed, and I, being a part of this process, moved with the energy of the group. At that time I felt confident we would be able to make sense of what we encountered when the time came to review our endeavours. I also held in my mind that drawing on the knowledge and skills available within the group, was the central intention of the research, therefore the freedom to develop a way of being and working together was valid.

The difficulty arose when we began to consider our own research achievements, and what this indicated for us as a group of nurses. We could all acknowledge and give voice to the achievements we had made in the work place, and all speak favourably about the value of nurses meeting together. However, writing in a way that reflected this process, and the quality of our knowing, became very difficult As I analysed the field data I found myself trying to extract cycles of reflection and action from within the group context. This was impossible because the nature of our inquiry encouraged a context where personal experience was more important than noting and generating cycles of reflection and action.

On reflection I realise that we were travelling together, with all of us exploring our own view of the journey. Our sharing together was not contained sufficiently to extrapolate cycles of reflection and action, decision making was more individual than collective, as each person explored and described aspects of their research experiences .This left me, as a researcher, with a vacuum to fill - Should I meet with each member of the group and ask them to tell me how they engaged and developed cycles of action and reflection in the workplace? - Should I honour the work we did together as a group and thereby include as much as was shared within the group? It seemed to me that each had value.

The key 'truth' for me at that time, was about the nature and intent of our working together. It was clear that as a group of nurses we shared our experiences in story form, and that these stories were a record of each person's field work and therefore contained research data. It was the process of inquiring into, and supporting the telling of stories, that helped us to identify significant issues and themes contained within our research experiences. It is therefore

important in writing about the second cycle to focus on the stories that were told and what they elicited. However this was not the way I began to write, it was only after I had tried out several ways to present the data that I realised the strength of story. Perhaps this was because part of my journey involved an exploration into my own ways of knowing and sense making, this also needs to be recorded.

The pathway out of my dilemma began to take shape at a supervision session where my use of story telling throughout my research journey was questioned. This questioning was in relationship to my use of story as a way of presenting my own personal experience; validity and theoretical frameworks were the issues. This challenge led me to explore story telling as a methodology, and although the task felt awesome at the time, my exploration became a source of enlightenment. I realised that story telling had been a way of sharing experiences in both research cycles.

In the first cycle stories were used to illustrate an issue or a point being made; in the second they represented personal experiences of research, as researcher and subject. This new perspective gave me another frame, one which allowed me to more fully present the experiences we shared within the group. It also made me aware that within this context, each persons' life strategy was shared and developed. The next chapter will bring into focus these two different perspectives. I will begin with the way we developed as a group and the agreements we made at that time. This will be achieved by providing an outline of how each person developed their own research intentions, and how we as a group, endeavoured to inquire into and support each persons' way of working.

I will then open up the dilemma as I saw and felt it at the time, including my awareness that much of what we did together within the group context was left unspoken. At this point, where I was feeling very uneasy about the quality of my research account, story telling as a methodology for exploring experience became the way through my dilemma. This step towards another way of viewing the second cycle allowed me to consider how our stories 'spoke to' our life strategies and informed our actions and intentions. Thus life strategies and story telling as methodology is the framing I use to explore experiences shared within the group, and experience as co-researcher and co-subject.

To create some coherence around ideas, methods and outcomes, the next chapter will give an account of my first sense making of the data gathered during the second cycle. I will then depart from the field work and present my understandings of life strategies and story telling as a representation of experience. This will provide a backdrop for revisiting the second cycle from another perspective.

Chapter nine

Introduction

Our agreed intention as we entered this second cycle was to pursue our own research within the workplace. We also whether meeting together to reflect on each person's research experiences created a deeper understanding of nursing, and ourselves as nurse. To achieve this we intended to use a Co-operative Inquiry methodology to explore our own practice and to present these research experiences within the group context. In planning for this second cycle we expected continue with the ways of working we had established in the first cycle.

The first cycle was centred on testing out ideas and feelings in the group setting, and noticing more fully our own actions and reactions within the context of work. The second cycle was more about refining our research ideas within the group context, by sharing dilemmas, and possible ways of interacting within the worlk context. These differences generated a process in the second cycle where thinking about issues, sharing ideas,, inquiring about experiences, and listening to each others accounts became more important than identifying and agreeing cycles of action and reflection. This does not mean that we did not use the processes of action and reflection to notice consider and act, we just did not use the time together to evaluate or present these activities in any planned way.

This chapter is an account of the second research cycle from the perspective I held as I entered into the process, collected field work data, and made sense of the research experience. Therefore I will begin with the first session because it was here we agreed to rigorously pursue cycles of reflection and action within a Co-operative Inquiry methodology. I will then outline the patterns that emerged as each person presented particular issues and developed personal strategies to meet perceived challenges - contextual and interpersonal. However, the degree to which each person's research is described in this chapter is limited to the material that was either shared within the group or shared with me in some other way.

Beginning the second Research cycle

The first group session was held in a community hospital and 'hosted' by one of the group members. The group began with an exchange of ideas about co-researcher and group participant roles. In discussing these roles we revisited the Co-operative Inquiry methodology and agreed to use action and reflection as a way of noticing and recording our experiences. This discussion was a useful exercise and clarified the way a Co-operative Inquiry approach could affirm both personal support and a critical awareness of our own subjective experience. During this process we also considered some of the patterns that had emerged during the first cycle of research, particularly self- disclosure and coherence between our intentions and our actions. We decided to continue raising these issues as a way of testing out personal integrity, and the effectiveness of our interventions.

These discussion uncovered some concerns about how rigorous we needed to be in using the tools of action and reflection, and how we would share our efforts. After some debate we decided to focus on reflection for action in the world, in action in the group, and about action as experiences were recalled and discussed. At the time this decision was made it seemed to 'fit' with our individual research intentions, however the process that emerged did not represent these different ways of reflecting and acting. In retrospect I realise that inquiry was more tentative, reflection more personal, and experiences were recounted in story form; only in part were the processes of action and reflection identified and commented on. However, by the end of this first group session each member of the group had re-affirmed their research intentions, set dates for future meetings and agreed to:

- share the management of the group meetings;
- inquire into our own practice and experiment with new ideas ;
- develop cycles of action and reflection based on practice in the work place;
- bring our own sense making and ways of knowing to the group;
- support and critically appraise each others practice;
- share ideas and personal experiences of our research endeavours.

This process of agreeing together as co-researcher and co-subjects, required that I adjust my role and develop a different mode of activity. My focus of attention and energy moved from the group and research process to my own personal experiences, and as I began to take a more participatory role within the group so my own stories emerged and in part were shared with others. This change in focus allowed me to explore my own thinking and acting in a more experimental way.

It was here that I increased my understanding of life strategies, gendered roles, the work of expert and innovative nurses, and organisation development. This exploration of ideas and understandings was achieved both experientially and through reading relevant texts. Consequently, as we developed a more participatory way of working together, and as I paid more attention to my own research and inquiry process, so I experienced a research journey that altered my way of viewing the fieldwork. Before exploring my own experience of this part of the research journey, it is important to attend to the way we worked together to support and inquire into, each persons research intentions.

Developing a pattern of working together

Each session began with an exchange of information about our personal lives, common interests, or work concerns. Time was then given to hearing each persons' need for time to talk about personal research related experiences. At the first session it became clear that several members of the group wanted to present issues related to their research intentions. We spent time discussing how involved each issue might be, and the time each person might need to present the issue and receive ideas and support. The process of agreeing priorities was very interesting because it was more about people 'stepping back', rather than stepping

forward. Several members made clear their wish to present relevant issues; yet when it came to deciding who warranted time, each person seemed to be saying "others' needs are more important than mine." Consequently our decision to share the time between two people left me with an uneasy feeling about those who seemed eager to talk about their issues but had 'stepped back'. I realise now that 'stepping back' when others have a need to discuss their personal experiences is a way of being that I share with some of my peers. This way of working with others is part of my own research experiences in chapter 12.

Reflecting now on why certain people were selected to present their experiences I realise that the degree to which each person seemed to be coping, or not coping, created the priority. A sense of being overwhelmed or forced to make ill considered decisions, was the cue for focusing all our attention on that person's experience. It is clear to me now that we were all 'tuned in' to situations that produce conflict or feelings of powerlessness; this became the established pattern for deciding who would tell their story. We made adjustments to this focus on problems and difficulties by creating a space at the end of each group session to share something humorous, or successful.

This pattern of beginning each session with mutually sharing something of our lives, then creating a space for one or two people to focus on important issues and ending with sharing our reflections, became established at the first session. However, this way of working created a different dynamic as we paid attention to one person's experience and acknowledged its uniqueness and potency. This change in the way we worked together is central to the dilemma I faced when I attempted to make sense of both process and outcome in terms of the chosen methodology.

After this first session I considered the process that had developed and the issues that were presented, and realised that I had become fully engrossed in the presentations to the point where my own experiences had resonated and created a new experience for me. I did not know how much this was the case for others, or whether contributing my own experiences would have been useful at the time. To probe this question I decided to record my thoughts and feelings in and about the group experience, and send it to each participant for their response. My rationale was to test out whether this way of expressing thoughts and feelings was a valid way of communicating what was not communicated within the group.

This act could be seen as me not wanting to let go of the facilitator role, I considered this and decided that if it is so then any response to my letter would enlighten me. In the letter I stated my concerns for those people who had intended to present issues and did not, and I reflected on the stories that were told. These reflections included my own experiences that resonated with those expressed, and my thoughts about the issues presented. I realise now that this way of communicating is familiar to me as I often write to colleagues in a similar way, the content may be different but the process feels the same. The response to my letter at the next session was an inquiry about meanings and a discussion about whether others felt able to

share their thoughts and feelings in the same way. Other ways of sharing ideas and related experiences were also discussed briefly with different members affirming personal possibilities. However, the process of reflection within and after the group was left entirely to the individual, the agreed focus of the group was each person's experience of pursuing their research intentions. Therefore it is timely now to recount the work each person did share within the group, or provided in other ways including writing, discussing between group session and engaging others in their work.

Understanding the nature of our research experiences

This section has been the most difficult to write because it is almost impossible to set aside what I now understand in favour of what I was struggling to represent at that time. In order to write this section in a way that is credible to me and informative to the reader, I have decided to consider each person's research in terms of their work context, experiences shared within the group, ways of engaging with the research and the tangible outcomes. I will follow this with my own interpretations and reflections at that time.

> The information I am providing has been shared with group members and is not personally sensitive

I realise, as I prepare to write this section that I contributed to this second cycle in a similar way to my peers, therefore my account of my research experiences needs to be written in the same form. I will begin with a profile of my own work context, and then present those experiences I shared with my peers, albeit not in their fullest form. This account is limited to the purpose we shared at that time, some of my personal experiences are in story form in chapter 12.

An account of my own research experiences

The work context

I began this second research cycle intending to focus on the role of nursing within a changing environment, paying particular attention to differing treatment and care perspectives and differing role expectations within a multidisciplinary context. My personal goal was to develop interpersonal relationships that encouraged a climate of inquiry. At that time I was working in a small addictions department within a mental health care trust. My role in this department was two fold, I was the senior nurse responsible for the nursing services and the service manager responsible for business planning and management.

In this duel role I worked closely with William who was, and still is, the Clinical Director responsible for both the delivery of clinical services and meeting the contractual agreements. The other key people in the department with whom I had a collegiate relationship were: David, Consultant Psychologist (also my husband) and Andrew , Drugs Consultant. The nurses in the department were at a different level of decision making, consequently my relationship with them was of a different nature and although important to achieving my goals within the

department, they are peripheral to the focus of my research intent. Two doctors, one psychologist and myself having a dual role, constituted the 'Core Group'.

As a 'Core Group' we held the responsibility for making decisions about service developments, education and training, and managing resources. Each core team member had particular agendas and ways of managing the new style NHS. William became interested in management issues and enrolled on a six month management course for Clinical Directors. David was studying for a PhD and took an interested in developing psychological treatments through collaboration and teamwork. Andrew was interested in harm reduction and health promotion related to drugs and HIV. I was involved in re-organising nursing work to meet the changing needs of the combined drug and alcohol services and developing community services. These different interests created colour and texture as well as difficulties in making decisions. In order to optimise the positive attributes of this group we met weekly, not necessarily to make decisions but to discuss and find some common ground on which decision might be made.

During the time I was involved in the second research cycle significant changes were implemented within the NHS, the Mental health Trust, and the Addictions department. The work culture was not receptive to the NHS changes mainly because these changes were seen as placing controls on clinicians that were not viable in the long term. Most people believed that if they were ignored they would go away. As a consequence I concentrated much of my energy on developing a relationship with William that fostered openness, honesty and a supportive stance to other members of the department. It was within this framework of role relationship and role expectation that I pursued my research intentions and shared these experiences with my peers. I realise now that it was the nature of this relationship that allowed me to be instrumental in bringing about changes within the department.

Experiences shared within the group.

The experiences I shared within the group were mainly in response to others' presented issues. This occurred when my own research experiences informed or mirrored the issues being discussed. My focus for developing cycles of action and reflection was my relationship with William and my intention was to develop this personal relationships by:

- engaging in a way that fostered trust and honesty;
- being clear about each others expectations within the relationship;
- An understanding of the others' purposes and aspirations;
- establishing a language that allowed meaning to be exchanged;
- an ability to manage the closeness and distance within the relationship.

I anticipated that this relationship would pass through stages, from engaging, to regulating the closeness and distance. In some ways this is so because I began with thinking about, and paying attention to, the process of engaging. However in the actual process of engaging I inquired into William's purposes and aspirations and this opened up an exploration of

expectations of each other, the services, and the wider organisation. Creating a context for ongoing dialogue allowed me to experiment with ideas and to surface a language we could share and use to make management decisions. However, in contributing to the group process with my peers I selected experiences and ideas in accordance with their 'fit' in terms of the issues being presented. Before I begin to discuss these contributions I will briefly describe the way my relationship with William developed, and the strategies I used to achieve outcomes acceptable to both of us.

Beginning the joining process

I first met William at the monthly business meeting I attended as part of my orientation to the department. I came to this meeting with opinions from a number of people about the department and the Clinical director. One interesting piece of information was that William considered Senior Nurses to be unnecessary and expensive, the money he declared would be better used to employ other staff. I thought this was a valid point and decided to use this information to test out his attitude to nursing and to me.

When I arrived at the meeting I found a very different person than I had expected, he was friendly warm and welcoming, so I decided to risk saying what I had heard. His response was to laugh and say, "Well I expect you to be different than the last one!" We then both agreed to wait and see what I was able to contribute and how well we could work together. My understanding at that time was that I would need to engage him in some real change fairly soon if our relationship was to be of any consequence to the development of the services and the staff.

Clarifying expectations

Before I began to establish a sense of direction within the department I spent some time with William trying to understand what his professional goals were. At first he said his goals were very simply, to see a few patients and to do some research. I accepted this statement, and with this in mind I began to re-organise the department in line with his and others' goals. Gradually William explored other possibilities with me, and during these discussions we shared our professional backgrounds and why we did what we did. In time we achieved a sense of balance in the way we worked together, with William taking charge of medical matters and particularly any differences between doctors. Whilst I took charge of nursing and any problems between nurses.

This acknowledgement of who took charge of what, was an important issue because conflict between nurses and doctors often emerges when roles are not clear and expectations are in conflict. This was a major step forward and as a consequence we were both able to discuss difficulties related to the clinical services and to find acceptable solutions. The management issues were a little more complex because at the outset William was not interested in the details of managing the department. However he did want to be involved in decision making in

and outside the department, the task of presenting unity to the 'world' was a challenge that required a shared sense of purpose, this was not easy to develop.

Understanding purposes and aspirations

Developing a relationship that explores personal aspirations is not something that can be prescribed and often develops by accident. As we did not establish regular meetings outside the structured management meetings our work together tended to be informal. This informality created an easiness of access and a straightness of talking, and although we came from different backgrounds and life experiences, we could accept and understand each others point of view.. However this was not always the case as we sometimes fought quite vigorously over developing an appropriate strategy for the changes needed within the department. We were also at very different stages of our own life cycles, William had a very young family that he was devoted to and I had children who were adults and almost independent. Our connectedness came from an interweaving of our experiences that allowed our different perspectives to find a balance. I was aware that William was ambitious to achieve a position of some authority and needed to be affirmed as a competent clinician and leader. I, on the other hand, did not aspire to any personal career ambitions apart from meeting my own internal values, however I did aspire to supportive and satisfying relationships.

This difference in personal goals encouraged a working relationship that gave William the public leadership role and allowed me take the supportive, facilitative role. I was at ease with this arrangement provided my integrity was not compromised and 'public' presentation were owned by both of us. I found a sense of purpose in developing a well managed department where people inquired and listened to each other. Being 'on stage' was something I was happy to leave to William. Most of my attentiveness to my own behaviour related to the interpersonal quality of this relationship and the effect this had on the achievements of the department.

A shared language for exchanging meaning

It is interesting to note that although doctors and nurses work within the same organisational culture they do not share the same professional culture. One could say that they represent gender opposites with doctors taking the lead in curing and nurses in caring. Curing being from an objective stance where treating is the norm, and caring being from a subjective stance where nurturing is the norm. Given these basic differences it is not surprising that the language of nurses and doctors often causes confusion when planning treatment and care is shared. My way of resolving this confusion is to use the language of doctors in ward rounds, when reporting back to doctors, and when writing patient notes that medical staff will read.

In working with William I began from this position because it allowed me to be 'heard'. However, when discussing management and organisational issues, I realised there was a gap in my knowledge about how William understood management. I explored this gap by inquiring

into the frameworks he used to understand and make decisions, I found that often they related to his own experience of being managed. Sometimes he would reflect on the techniques of people he admired, sometimes his experiences with his children or with patients, and sometimes we would discuss books he had read. This gave me some ideas about the areas of thinking and understanding we might share. At a certain point in our relationship I decided to take a risk and test out his receptiveness to new frameworks that might resonate with his own.

I introduced Torbert's developmental model as it related to managers and organisations, by offering him a copy of the first part of Managing the Corporate Dream (Torbert 1987).

(This work is related to life strategies and will be in the next chapter.)

William found this developmental framework matched some of his understandings about how people behave in organisations. We spent some time discussing the possibilities of the framework and it became a 'working' document that both David and I shared with William. Torbert's language became a vehicle for understanding ourselves and others we worked with, it also provided a structure for planning interventions in the wider organisation. It is worth noting that from my point of view understanding the concepts and the outcomes associated with the different levels of development does not produce competence, understanding why, and knowing how, was something we wrestled with. The situations where this confusion became evident are contained in some of the incidents I shared with my peers.

Managing closeness and distance

This part of our relationship is difficult to write about because it could so easily be misinterpreted. However, I need to write it because I valued, and still value, the relationship we developed and because William's message to me when I left the department was - "Thank you for all the caring and control". This, I believe deserves some notice and response from me; this is my attempt to respond with honesty.

From my experience, the degree of closeness and distance in a relationship becomes an important issue when there is an intentional openness by one or the other, to the other's needs. Developing a relationship where it is acceptable to inquire into another persons feeling state necessarily encourages closeness. Acknowledging the difference in life strategies, and life paths, and giving space for this to be pursued in turn creates distance. Carrying these two important aspects of any continuing relationship will at times create misunderstandings and painful experience, as well as new knowledge about oneself and feelings of being 'at one' with another.

My beginning relationship with William was one of 'touching' occasionally but treading different paths{distance}. I was busy managing, and he was busy treating patients, we met to exchange a little about those two worlds. Sometimes I would request time with him to discuss budgets and plans, his restlessness would cue me in to his level of interest and attention span. As we moved towards implementing changes we also began to share an understanding of how

we could support each other and get the work done. This encouraged more frequent meetings for shorter times.

We met to inform each other of developments, changes and possibilities, and to some degree this was about mutual support and personal consideration. At times we shared our personal backgrounds and the conflicts we were experiencing at work, often our discussions were fleeting. However, I was aware that William was becoming more interested in the art of management and critical of some of his medical colleagues. I was watchful of this development because some of the initiatives we were pursuing could have ultimately place William at odds with the medical fraternity. To counter this I supported and encouraged him to keep this relationship open, acknowledging that the medical culture is a closed one. If one is a doctor it is important to be inside the medical culture not outside.

Our ability to talk together about our professional cultures allowed me to share the tensions I hold in relationship to maintaining my own integrity and coping with feeling vulnerable. William, on the other hand could talk about his anger and feelings of alienation when defending the rights of young doctors and the resultant criticism by his own colleagues. Reflecting back on these experiences I realise that in listening to another's experience and inquiring into the meaning they make of it, has an intimacy of knowing that cannot be set apart from one's sense of being. I recognised this sense of knowing as caring for and with another. It was not until my departure and William was not able to achieve his particular ambition that I realised the degree to which I cared.

Managing closeness and distance in relationships where a sense of trust and honesty is intended, will inevitably pose some problems. When caring for patients nurses learn to manage this, usually by withholding personal self. In colleague and peer relationships personal disclosure is more likely to enhance the relationship by freeing up each person to contribute fully. The intimacy that this creates is managed on a daily basis and rarely acknowledged or even named. It is the ending of a relationship that brings the depth of caring, for and about the other, to consciousness.

My contributions to others research

The personal relationship that I developed with William was central to my own research and provided experiences that I was able to share within the context of others experiences. The issues that were presented encouraged us to explore

- relationships that risk vulnerability and powerlessness;
- managing changes where conflict is a part of the process;
- role expectation and role conflict;
- creating a context where inquiry and working together is affirmed.

I also contributed ideas about nursing, personal life strategies and developing interpersonal competence. I offered these ideas to provide a frame for managing particular issues, as a way

of making sense of our own thinking and knowing or as affirmation of a particular experience. Some of these ideas have already been discussed in chapter 2 (the primacy of caring, research as praxis and the genderedness of nursing). The ideas associated with personal life strategies and interpersonal competence (chapter 10) will provide the theoretical stance for revisiting experiences and creating a different understanding.

Ways of engaging with the research.

Engaging with the research took the form of:

- recording my understandings, feelings, uncertainties and personal experiences in letters to group members after group sessions;
- keeping a diary of my own reflections and other's sayings that seemed to hold some significance, either because they resonated with my own experiences or because they caused a jangle in my head;
- reflecting in action as I worked with William and reflecting on the actions that were taken as a result of this reflection in action;
- discussing issues and ideas with others to tease out an idea, or make sense of an experience;
- writing as a way of sharing ideas and crafting a consensus understanding of an issue. This kind of consensus was often achieved after a common vocabulary had been decided and a sense of purpose had been reached.
- taking different points of view and 'feeling' what it is like.

My use of a variety of methods to probe an idea or a situation is about my need to understand different perspectives and to 'take people with me' if that is at all possible. I am aware that I submerge my own understanding of a situation or idea in favour of valuing collaboration, teamwork, a sense of belonging and an affirmation of difference. My own life strategy stands before me as I write, suffice to say now that I was unclear about this relationship when I first attempted to write an account of the second cycle. My strategies were clear to me at that time but not clearly linked to my understanding of myself and the way I approach and live life.

Colin's research experiences

The work context.

Colin had recently been involved in developing a services aimed at harm reduction and health promotion within a drugs service. The focus of his work was a group of homeless people with severe drug problems, and generally troublesome to General Practitioners, drug services, and the general population. Most of these people were using crime to finance their drug habit, as a consequence they were not easy people to work with. Colin found the work both challenging and very wearing, it required that he work closely with doctors, because prescriptions were a vital 'currency', and with the chemists, police and probation because the service was open to abuse.

Colin's research focus was the clinic where the people came for their scripts, doses of methadone and/or education about harm reduction. The services provided by the clinic were set up in haste, however the ability to recruit people with an interest and experience in the work was difficult. At the time we were meeting Colin had recruited a group of registered and unregistered nurses and was supported by a junior doctor and consultant. His wider network included other professional and voluntary workers involved with the homeless.

Experiences shared within the group.

Colin intended to develop a Co-operative Inquiry approach to working with both the staff and the customers. He decided to focus first on developing an inquiry group with the nursing staff and later to involve the customers. This field of nursing was new to most of us in the group and required some understanding of the issues and the problems before we felt comfortable about offering ideas. Colin told us how he wanted to develop a team able to share ideas and take responsibility for managing individual care plans. He also talked about his own experiences of working alone in transient accommodation, and the issues of control that are ever present with this group of customers.

However it was the difficulty in developing an appropriate way of working with very inexperienced staff that became the focus of the first cycle of action and reflection. Colin decided to begin with providing educational sessions for the staff. These were aimed at promoting confidence so that agreeing ways of working together, and the protocols needed to manage the service, became possible. Colin intended to use an inquiry approach to achieve this and a shared reflective diary for all the team to recorded ideas, problems, issues, and difficulties.

Later in the research cycle Colin gave an account of how he had developed the group and what they had achieved. He told us that the first stage worked well with discussions arising from the teaching sessions. However when it came to making the ideas happen, and reflecting on practice, the nurses did not feel confident to take an active part. It seemed that this team of inexperienced staff were unable to contribute to developing a service in the way he had envisaged it. In his words - "They let me do all the talking and just wanted to follow instructions." Colin shared his anxieties about delegating work, the risk of customers getting violent or getting more drugs than they should, was a constant worry for him.

When this was pursued it appeared that Colin was not sure if the junior doctor would 'stand by him', and he wondered how much commitment the nurses really had to this client group. We explored this and discussed possible ways of managing groups and delegating tasks, we also suggested that a closer observation of his own role might be a useful way of understanding what he could, or could not do. At the next group meeting Colin was much clearer about his own role and expressed the tensions he felt working with drug addicts, and doctors who did not want to work with this group of clients.

Colin developed another strategy for managing the group. This involved being clear about the decision that he needed to take and the decisions the nurses could reach amongst themselves. This way of working together provided a context for discussing and inquiring into different ways of working. Involving the customer in the process, Colin considered, was more difficult and could not be the responsibility of inexperienced and unsure staff.

Ways of engaging with the research.

Colin used a team diary to record meetings, what happened within the clinic on a daily basis, and the comments and ideas of team members. He also used a Dictaphone to record his own ideas and concerns, and shared these with the consultant that he worked closely with. This relationship with the consultant, was also an area of work that Colin paid attention to, however he did not discuss this within the group.

Jane's research experiences

The work context.

Jane had recently taken up a nurse manager position in community hospital providing maternity, minor injury, short stay medical and long stay elderly services. The hospital adjoined a health centre and therefore some facilities, resources, and services were shared with general practitioners. As nurse manager Jane was involved in managing the hospital including all the staff, according to Jane this new position held both opportunities and problems. Many of the staff lived in the community and had been employed in the hospital for a long time, consequently customs and practices were well established. The doctors also had a sense of ownership and expected to place elderly people in the long stay beds without considering the length of stay or the quality of life.

Jane shared with us her vision for the hospital in terms of working relationships with General Practitioners, and encouraging staff to work in teams so that the patients had full benefit of all the resources. She envisaged every one working together to achieve a good service to the patients and their families. However there were many obstacles to achieving this, the one causing most difficulty was the conflict that surfaced between different disciplines when each held fast to traditional ways of working and saw no reason to change.

Experiences shared within the group.

Jane presented her ideas about the nature of team work and the way people were functioning within the hospital. Many of us were able to share similar situations of conflict between people with very different agendas. To help Jane develop her approach to this conflict we inquired into the roles of different people and how they did, or did not, work together. This encouraged Jane to develop a map of the people involved and to test out the degree of support for multidisciplinary team work. This took some time, as Jane made interventions into the system and noted her own thinking and feeling in different situations.

Serious conflicts occurred when Jane took the initiative and decided to change the way day patient services were provided so that patients were not sent home earlier than appropriate. Planning to change the way people worked in order to meet the needs of patients brought resistance and personal criticism. Jane managed this by using the 'map' of people that were for the changes, she also used the tools of reflection and action to monitor her own thinking and acting. Sharing the stages she went through with us and tested out her integrity, and authenticity, by inviting us to inquire into why, and how, she had decided to make particular interventions were part of this process. We were all able to identify with this situation as many of us could recall past experiences where our own integrity and sense of 'right' was pitted us against the wants and wishes of others.

Ways of engaging with the research.

Jane engaged in the research primarily by recording her own reflections in a personal diary. This became the resource for clarifying her own personal agendas and the actions that needed to be taken to test out the decisions made. She also consulted with colleagues and senior nurses outside her own hospital services. Team building exercises, and problem solving groups were used to managing the change process.

Mary's research experiences

The work context.

At the point of joining the first research cycle Mary was a staff nurse working with the elderly in a community hospital. At the time we began the second cycle she had been promoted to sister. Mary expressed her intentions to develop a team of nurses who were able to work together in a co-operative way, sharing the workload and providing individualised care to all the patients. Mary had achieved some changes already but felt that there was no cohesion within the staff group and this led to some patients receiving better care than others. Mary's staff were a mixture of trained and untrained nurses, and a ward clerk. Some of the nurses, particularly the untrained, had worked in the ward a very long time, however most of the trained nurses were new graduates with very different ideas about caring for patients. Mary's difficulty was in viewing all the staff as equally valuable because her natural inclination was to give responsibility to the new graduates. and yet she knew that experience was particularly important when caring for the elderly.

Experiences shared within the group.

There were a number of issues and experiences that Mary shared with members of the group. These included:

- points of view that staff held about changing the way they worked on the ward;
- ideas she had about individualised care and her experiences of this practise;
- discussions with General Practitioners about the use of the beds in the ward.

Mary decided to begin the change process by bringing together small groups of nurses who wanted to work together and explore team decision making. She gave people responsibility and encouraged team leaders to manage care planning for each patient. This promoted individualised care plans and teaching sessions which in turn promoted standard setting. Mary brought to the group small scenarios of success, challenges and failure. She did not take a central role in presenting an issue but something of what she was doing seemed appropriate to the issues and concerns of others. It seemed that through her own planning and paying attention to her own and others' interactions she was able to create a context for team work.

From Mary's point of view the one intervention that made the difference was an 'away day' planned to bring all the staff together to affirm the changes to individualised care. To achieve this Mary successfully convinced the General Practitioners to manage the ward with help from 'bank' nurses so that all staff could attend the 'away day' and be part of the decision making.

Ways of engaging with the research.

Mary used a reflective diary, voice activated tape recorder, consultation with peers, team meetings, an 'away day' and research into the way other nurses have managed change in nursing care. Mary also wrote an account of the 'away day' and sent it to me. Twice during the second cycle I was invited to discuss teamwork with her staff.

Eve's research experiences

The work context.

Eve was a nurse manager with responsibility to develop close working relationships with general practitioners. Eve also had teams of midwives, health visitors and district nurses within her span of responsibilities. The NHS reforms and the move to GP fund holding brought considerable changes to the work of people like Eve. In the past she had developed very good relationships with her staff and with general practitioners, the market economy seemed to produce a negative effective on her role.

Experiences shared within the group.

Eve stated that she wanted to understand and work through an ongoing conflict involving her new sector manager. From Eve's point of view an integral part of this conflict was about shifts in power and authority and a reduction in resources to do the job. To help our understanding of the situation Eve talked about the changes that were occurring in the services. These changes were causing a high degree of stress as pressure increased for more activity and at the same time resources were difficult to access. Eve described her own vulnerability as nursing positions were being cut, and non-clinical managers appointed to manage the services.

Eve became very emotional as she recalled the letter she had just received telling her that she had been replaced on the Family Health and General Practitioners committee. There had been no discussion with Eve We explored this episode inquiring into the difficulties that we

were all aware of. Eve then made reference to the conflict around her relationship with the new Chief Executive and I noticed during the discussion Eve moved between frustration, sadness, anger, outrage and vulnerability. We all made efforts to understand the dynamics, share some of the feelings of powerlessness and respond to her feeling state. Gradually we focused on possible interventions and considered the people who might support or conflict, this provided a clearer perspective for suggesting ways forward.

During the session members of the group were able to bring different points of view to bare on the situation, each of us could identify with aspects of her experiences. Clare was able to join with Eve around the issue of the Chief Executive and said that she is well known for having her favourites. Jane was able to explain some of the issues that were going on with the General Practitioners and how they were beginning to 'flex their muscles'. I inquired about what was driving the waves of feeling and despondency and found that it seemed to be about a fear of really losing control. Handling the chief executive seemed to be the major issue distorting her ability to manage the day to day nursing issues.

We all agreed that the life of a nurse manager is not easy at the best of times- "everyone wants you to do for them no one wants to respond to your cries for help". My concerns during Eve's presentation was about how a situation emerges that places nurses in conflict with nurses and then old stereotypes emerge. I found that I identified when Eve talked about -

> "dropping what you are doing to make life smooth for others, and the sense of satisfaction knowing you have the ability, the networks, and the authority to get things done. In contrast is the inevitable feeling of frustration and let down, when others have left work unfinished or lack the skills or knowledge to do the job, and are unconcerned about the confusion they have created."

I shared some of the ways in which I have learnt to survive change, and even turn it to an advantage, however bleak it seemed at the time.

Eve decided that she needed to focus her attention on her position vis a vis the Chief Executive. We understood this relationship to be important to her future and her ability to function, therefore we offered support and information outside of the group setting. Eve fed back regularly and others who worked in the same field supported her through some of the difficulties she faced. Eve's presentation engaged the group for a major part of one group session, the difficulties she faced were not unfamiliar to many of us and we all knew that we could be in a similar position in the future. Anxieties were heightened during this session and we took some time to disengage at the end.

Ways of engaging with the research.

Eve used a personal diary to record her thoughts and feelings and peer relationships to reflect about her actions in the work place. Members of the group also provided support in carrying

out actions and Eve selected an experienced nurse as a mentor to guide her through some major decisions.

Clare's research experiences

The work context.

Clare worked in a School of Nursing recently transferred to a university programme. This transition was very difficult for both students and tutors, and for some caught up in the final phase it is still a traumatic time. The process of change involved a five year period and for some tutors job security was affirmed very early, while for others anxiety about the future is still present. This occurred because some tutors already had degrees and a secure role, and others were sponsored to complete undergraduate or post graduate degrees. Clare had completed an undergraduate degree but as yet not secured a lecturer post on the new course, instead she had responsibility for working with the students completing the 'old' course. During the time we met as a group Clare had not secured a permanent position. She had however become involved in working with clinicians who were mentoring the 'new' students, and in validating the final examinations for the 'old' course. During this second cycle Clare enrolled for a PhD in education and intended to research the effects of the changes on nurses completing their training under the old system and beginning under the new system.

Experiences shared within the group.

Clare presented the conflict endemic in being a validator for nursing examinations and providing personal support to students. During the discussion Clare formulated the question:

"Can a team of external examiners assert their responsibility to ensure that the rights of students, and tutors, are represented when resources are allocated so that their contracts are honoured and the past is not devalued for nursing?"

Clare talked about her work with the team of external validators and the possibility of addressing some of the unanswered issues about the changes. This was explored from both student and tutor's point of view, gradually ideas linked together. Clare then posited the idea that she should write to the other validators requesting a meeting to discuss this possibility. We all agreed that this would be a useful first step and even if there was little that they could do it would bring people together to explore the issues students were presenting.

My thoughts were that this could be a very difficult situation to get into because it relied on others to carry out the proposals, external validators have no real influence on the way students are treated outside their educational programmes. The resource issue was more about implicit statements of the value placed on each group of students and the tutors who taught them. However, it seemed to me that by taking the risk and putting thoughts and concerns in writing a more helpful solution might develop.

The questions then arose around the idea of bringing external validators together:

"Could this be a nucleus of a support network across the schools of nursing?"

"Is it possible to surface the needs of the students and tutors so that priorities can be set, and some negotiations entered into?"

Having discussed her concerns and issues Clare went away to find out the answers to the questions posed. Clare returned to the group having made some decisions about the way forward. She had developed a network of nurse teachers, some in a similar position to herself. She had also made a firm commitment to work towards a PhD in education. Within this degree she intended to research the effects of the changes on both new graduates and past students. Not long after this decision Clare left the group to develop her own research group, we all agreed this was a good choice. Clare is now taking a lead role in developing a new post graduate degree in education within the Nursing Institute, this is still not a permanent position but it does allow her to pursue her studies.

Ways of engaging in the research

Clare used a reflective diary and taught students to do the same. She also set up student groups to inquire into their perceptions of being a student on a programme that was closing. In writing to her colleagues she developed her own thoughts and feelings about her own position and established a support network. Most of the results of this work went towards developing the groundwork for her own higher degree.

The Research Experiences of Sara and Linda

The remaining two group members did not present their own research, and because each was involved in very personal work I did not inquire within the group setting. Therefore their contributions were responsive to others agendas rather than accounts of their own. I intend to mention these contributions when I revisit this second cycle and explore a different perspective.

Interpretations and reflections

As I gathered together all my field work notes and records and paid attention to the different representations of this research cycle, I experienced a conflict between my intentions to write about our research experiences and my personal experience of our activities together. The tension was between identifying the way we developed cycles of action and reflection as we managed the research cycle and assessing whether working together as a group enhanced our ability to practise effectively as nurses.

At this point I decided to put aside my experience of being in the group and focus on each person's account of their research experiences. Therefore at the time of writing this chapter I did not intend to create another dimension for understanding the way we shared our experiences. I was strongly attached to giving an account of the way we met our research intentions. However, in doing this I found it difficult to identify cycles of action and reflection because each person made their own sense of their research cycles. I could only make sense

of what was shared within the group and this left me with a vacuum; exploring this vacuum led me to a new way of understanding our work together.

Although we had brought together and pursued many shared issues I did not take account of this flow of ideas as I reviewed the data. I asked myself - Why not? - It is clear to me now that I ignored or failed to notice the importance of the way we shared and explored our experiences, and the conclusions we came to about our actions. Having now acknowledge the value of what we achieved, both individually and collectively, I am able to create a different research text, one that considers the research journey, our capacity to research our own practice, and our ability to develop and sustain an inquiry group.

I now realise that the first cycle developed some shared understandings about nursing, an ability to use the group to discuss personal experiences and an understanding how to inquire into our own practice. The second cycle emerged out of the first, and provided a context for sharing and discussing personal experiences about our professional practice. These activities were planned and managed by individual members as they pursued their research intentions and the group provided a context for exploring and developing our practice.

In truth I suspect this was more about colleagues acting as a reference and support group to inquire into practice, rather than planned and evaluated cycles of reflection and action. This brings into question whether we were participating in cycles of action and reflection within a Co-operative Inquiry methodology, or participating in an inquiry about our own experiences of reflection in action in Torbert's terms. Whether we actually paid attention to experiences in action, or whether we created possibilities, took action, and reflected upon it, is not transparent. From my own experience, situations where we reflected in action and altered our behaviour as a consequence, were brought to the group, as also were reflections about actions that led to decisions about future actions.

This debate brings into focus the methods I explored in chapter three, and highlights the overlap between Torbert's Action Science and Heron's Co-operative Inquiry. It seems to me now that these forms of human inquiry rely on self awareness, self consciousness, interpersonal skills, and a life strategies actively receptive to others, to oneself, and the world. These were the skills we were struggling to develop as we researched our own practice, and shared our experiences.

In Part 3 I intend to illustrate the way we achieved this by revisiting the second cycle, and giving a second account of the way we worked together and managed the research cycle. However my plan for achieving this required that I begin with how I have come to understand the connection between life strategies and gender. This is necessary because it was at this time in the research journey that I began to see the way our life strategies were interwoven with the genderedness of our roles. Once I have provided this 'backdrop' I will then discuss story telling as a methodology for understanding experience, this will provide the frame for revisiting the second cycle.

Part Three

Chapter Ten

Introduction

Part one has brought into focus:

- my experiences as a person and as a nurse through storytelling;
- my understandings of nursing from my own and others' experience;
- my search for a methodology compatible with how I experience nursing;
- the processes I used to engage participants and manage the field work.

Part two has provided a journey through the first research cycle paying attention to:

- The development of the group and the management of the process and the task;
- The dialogue that illustrated the key issues and concerns;
- The facilitation of the group and the management of the research data;
- The problems and difficulties in agreeing themes and managing conflict;
- The difficulties in writing a full account of the second research cycle;
- The need to revisit the second cycle to explore the way we inquired together.

It is clear to me, and hopefully to the reader, that writing this research text has been influenced by my own participation in the field work, the methodologies I used, and the journey I have travelled. These evolving experiences are a vital part of the research process and need attention before I revisit the field work.

Coming to know my own life strategy has been a central theme for me, and although I shared ideas about interpersonal competence and life strategies with my co-researchers, the ideas that I developed about life strategies and gender remained a subtext. Therefore it is important that I make clear to the reader the ideas that I have developed as a result of doing the research, and how my own life strategy has been exposed and informed by listening to my own and others' stories.

Interpersonal Competence and Life Strategies

The connection between interpersonal competence and life strategy has focused my mind for some years, searching for greater understanding is coherent with what I understand to be an important aspect of my life strategy. Immersing myself in this research has given me the opportunity to reach another level of understanding, travelling along this path has enabled me to engage with three particular writers: Marshall (1984), Belenky (1986) and Torbert (1981). All three have overtly or covertly provided ideas that enhance interpersonal competence, gender identity, and ways of knowing about oneself and others. Each one has given me something special in helping me to understand parts of myself and the way I interact with others, particularly at work. Torbert (1981) writes in a way that speaks to my masculine self, Belenky et al (1986) to my feminine, and Marshall (1984) provides a way of holding each lightly and engaging with others in a purposeful, confident and self reflective way. I will begin this pursuit of life strategy and interpersonal competence by discussing Torbert's ideas because it was reading Torbert's work that first gave me a focus for exploring my own, and others, interpersonal strategies.

Interpersonal competence as a life strategy

There are three writings of Torbert's I found useful in developing my understanding of self and others. The first is the search for coherence in professional and personal interactions, ('Interpersonal Competence', 1981) the second is the development of leadership skills appropriate to an organisation's developmental stage, ('Managing the Corporate Dream', 1987) and the third is about nurturing 'liberating structures' within organisations so that a climate of inquiry is fostered and valued ('The Power of Balance', 1991). In all these writings Torbert focuses on interpersonal competence as the key to developing a culture of inquiry. In doing this he confronts the need for congruency across purposes, strategies, behaviours and effects (Torbert, 1981). It is the awareness that incongruities need to be noticed and corrected that led Torbert to define interpersonal competence as:

"---the capacity in one's work and play with others:

- To clarify , to formulate and to do what one wishes;
- To test for and to correct incongruities among wish (purpose) formulation (theory or strategy), action (interactive process), and effect;
- To help others do the same, given the limits for mutual commitment." (p.178,Torbert, 1981)

This definition incorporates multiple possibilities about what one communicates, the way one communicates, the context in which the communication occurs, and the choices that each person makes about their own behaviour. Torbert arrived at this rather complicated definition after considering the two main interpersonal strategies presented by Argyris and Schon (1974)

in their research and experiential work with professionals and graduate students. Their claim is that the preferred interpersonal strategy, almost exclusively used both in college and in the workplace, is the 'mystery-mastery' interpersonal strategy. They also point out, according to Torbert, that this preferred strategy is incongruent with the common belief that interactions with others, if they are to be productive, should be open and collaborative.

According to Torbert, Argyris and Schon identified the governing variables of this 'mystery mastery' strategy as:

- Define goals and try to achieve them;
- Maximise winning and minimise losing;
- Minimise generating or expressing negative feelings;
- Be rational. (p. 174, Torbert, 1981)

It follows that if one pursues this kind strategy, collaboration and openness about one's thoughts and actions is unlikely to eventuate and, according to Torbert, the consequences of working within these identified variables are more likely to be:

- a lack of collaboration about purposes or openness to altering the task;
- inability to risk changing goals and appearing weak;
- a resistance to showing, or responding to, negative feelings for fear of being seen as incompetent or lacking in diplomacy;
- a focus on objectivity and suppression of personal feelings.

This interpersonal strategy is self oriented and designed to maximise winning and gaining and maintaining unilateral control. However, as this is a win/lose strategy, it is highly unlikely that everyone will win. Losing then becomes failure, not a point for reflection and change. In a changing environment where there is a need to work together to 'keep ahead', this strategy does not seem a useful one.

Torbert favours the idea of an interpersonal strategy that affirms the changing attitudes within the context of work, social relationships, and the nature of adult education where co-operation and peer support is to be encouraged. Torbert (1981) then takes the next step and contemplates the 'inquiring interpersonal strategy' as presented by Argyris and Schon. This strategy also has governing variables:

- Maximise valid information
- Maximise free and informed choice
- Maximise internal commitment to decisions made.

This presents a very different framework for interaction, relying on the behaviour of participants to bring about change in knowledge and skill. For this framework to be effective it is necessary for each participant to accurately report what they see, hear, feel, and think within a given

context so that decision making is informed by discussion, debate, and careful thought. With this in place, decisions about commitment and action are likely to be more rationally taken and intrinsically satisfying.

Torbert affirms this move towards openness and reflection, however, the point is made that the discrepancy between understanding the need for a new strategy and actually developing and using it requires further development in thinking and acting. Torbert identifies three main areas of difficulty to be overcome:

- If one already has an interpersonal strategy, then it is easier to modify this strategy, but not so easy to learn a new strategy in conflict with the old.
- These kind of competencies rely on skills, knowledge and experience. Skills can be taught, but it is the 'live' experience that develops competence.
- Teaching this kind of interpersonal strategy within an educational setting is almost a contradiction in terms. The context of a traditional education setting does not encourage openness, honesty, and risk taking.

In considering these difficulties, Torbert identifies the factors that need to be managed in order to provide a more fruitful context for such competencies to develop.

To achieve this Torbert turns his attention to each person's actual practice and questions how valid information about this practice can be elicited. Clearly, the question of what is valid information needs to be explored from a wider perspective than professional behaviours that relate to the agreed task. There are aspects of effectiveness that are influenced by the role each person plays within a given context and the interpersonal processes that emerge. According to Torbert (1981) -

> "----the governing variables Argyris and Schon propose for the inquiring interpersonal strategy are offered in universalistic analytical language that provides no clues about timing, about when and how to focus one's attention as they suggest." (p.178)

The process of managing this new strategy is vital to any real change in both purpose and outcome. Successful change involves being responsive to the unique context in which each individual works and acts, and having the skills needed to change the behaviour of self and others within that context. This is not easy to teach or learn.

It is clear that changing from one strategy to another is about wanting to act differently because one desires different outcomes. Having supportive colleagues willing to give honest feedback and a different point of view helps the process along. In developing a strategy to support management students to make this transition, Torbert focused on the use of power, particularly in the class room. He notes that if teachers do not use their own power then students do not have the guidance they need and if the teacher tells or corrects then the student is not free to make choices. The answer to this dilemma, he says, is to concentrate on

the task, the process, and the purpose. The trick, according to Torbert, is to focus first on the process, the here and now of it, and then to bring in the purpose as the students begin to grasp the skills of inquiring, listening, and giving feedback. This way of working requires observation, formulation and expression at each layer of interpersonal life, and presupposes a thinking, acting and feeling relationship with others.

To illustrate this growing interpersonal process, Torbert presents different dialogues in which work groups seek to find answers to common problems. Presenting people within the context of their work is one of the strategies Torbert uses to illustrate the movement towards interpersonal competence. This presentation of the 'live' situation is one of Torbert's strengths and demonstrates his commitment to:

> "--a community of inquiry- a lifetime circle of friends who can help clarify , and when necessary challenge, each other's purposes and actions." (p. 176, 1981)

This theme of developing a community of inquiry over time and context moves across the explicit centre of attention in Torbert's writings. For example, in writing about Interpersonal Competence (Torbert,1981), the centre of attention is on people learning new strategies and the focus initially is on students in higher education and the workplace. In 'Managing the Corporate Dream' (Torbert,1987) the focus is the organisation and the development of leadership skills for both the individual and the organisation, where stages of development for each are identified. In contemplating 'The Power of Balance' (Torbert,1991), the focus is on power and the need for managers to move between the various forms of power in order to develop transforming structures.

It is this theme of developing a community of inquiry that connects with my own ways of working. The techniques, structures and frameworks are important because they make explicit the path that Torbert takes, both to achieve his own purposes and to discover other possibilities. In order to make these connections between Torbert's ideas and my own ways of working, I will briefly outline his ideas about developing management leadership. Then I will address his ideas about power and liberating structures.

Managing organisations

Torbert anchors much of his practice on clear theoretical statements and developmental structures. To achieve this he creates frameworks for action and uses these as way of measuring effectiveness. One of these frameworks is designed to lead an organisation through multiple restructuring in order to achieve the 'Corporate Dream' (Torbert,1987). The framework is developmental and provides stages of managerial and organisational change (Figure 1). These stages describe steps in the development of managerial competence and organisational development.

The first Six Stages of Development

	Organisations	Persons
1	*Conception*	*The Impulsive Manager*
2	*Investment*	*The Opportunist*
3	*Incorporation*	*The Diplomat*
4	*Experiments*	*The Technician*
5	*Systematic Productivity*	*The Achiever*
6	*Collaborative Inquiry*	*The Strategist*

Each stage in the development of the organisation has a task to be achieved and each stage of personal development has a focus of attention. Between each stage are transitions that require changes in ways of knowing and acting in order to move to the next stage. These transitions are a challenge to the organisation as a whole and to individual managers. Successful transitions require that someone in the organisation is able to function at all stages of leadership development in order to take a meta view and manage change. With this leadership ability, the corporate dream is developed and communicated to all managers, and each manager is supported through the appropriate transition thereby creating an more sophisticated organisation.

Managerial competence and organisational development would seem, at first glance, to be directly related. That is, managerial competence equates with organisational development. I am not sure that Torbert actually believed this to me so - certainly he comments that a manager functioning at one particular level does not necessarily aim to achieve the next. It requires a leader with an 'eye' for the potential for change to facilitate this development. Thus, according to Torbert, managers of organisations need to be functioning at a higher level than the organisation itself if they are to create a vision and a strategy for transformation to occur. However, although individual managers have different styles of management that match the defined managerial competencies outlined by Torbert, I do not find a direct correlation with the development of the organisation. Two particular factors seem to have a considerable bearing on organisational development and whether this can be managed through central leadership or not. The first is the culture of the organisation and how power is located, achknowledged and transacted. The second is the external environment and the degree to which this either places conflicting demands upon or positively affirms the organisation.

From my experience of working in large public service organisations, both managers and clinicians can present at a range of stages of development, from opportunists through to strategists. Some move between all the possibilities and some exhibit a preferred style. I

observe very experienced technicians acting in an opportunistic way and people in executive positions being less than strategic, not aspiring to any clear purpose. I find it very difficult to make judgements about the 'level of development' of individuals from the way they behave in a particular context. It is only in working in an interactive way with people that a clearer picture emerges. One might say that this the nature of organisations and that people will behave differently in different contexts. If this is so, then the focus of attention needs to be on developing contexts where collaboration is affirmed, rather than diagnosing individuals. However, this assumes that people will choose to behave collaboratively it the option is presented (not necessarily so). According to Torbert, developing interpersonal strategies that favour collaboration, when other strategies are predominately in use, is not easily achieved. Large organisations are complex, with different stages of organisational and personal development occurring simultaneously. Therefore, the ability of an organisation to achieve a transition does not just rely on one person's leadership. The power of the chief executive is not all encompassing as one might expect, particularly in organisations that have multi professional agendas and power relationships defined by external bodies. Finally, it seems to me that there is an implicit framing within Torbert's developmental stages that is independent of both context and time and the complexity of transactions. This feels distant from my live experiences and the sense I make.

From observations of myself and others, people behave differently in different situations. For some (mainly clinicians), management and corporate issues are not highly valued. For others (mainly managers), clinicians hold too much influence. However, when both groups join together around critical incidents affecting patient care, then a collaborative process emerges and those who might be labelled technicians or diplomats become achievers or even strategists for that space of time. For me this has something to do with span of focus, ownership of the issue, and the power one holds within that particular context. As I meet and talk with people I am often surprised at their personal analysis of what is happening around them, and what might be possible. Creating contexts for action inquiry is achievable within a large organisation without a highly developed executive manager if multiple communities of inquiry are developed and linked together, this process, I believe, can transform an organisation.

The central resource that Torbert offers me, within my own work experiences, is a language to discuss corporate ideas, leadership, and organisational issues with clinicians and managers. By using Torbert's concepts and language I am able to join with others, and in so doing, to clarify joint purposes. To this end I am able to move within, and between, the defined stages of development and encourage others to take more flexible roles. However the developmental hierarchy, in its strictest sense, does not fit comfortably with my experience. I find Torbert's ideas of power more integrated with my understanding of managing multiple perspectives.

Forms of Power

Matching the use of power with purpose, process and desired outcomes, sits more easily with my need to adjust strategy to time, place and the perspectives of others. These ideas of power and their relationship to the development of liberating structures are central to managing in a complex environment. Consequently, they deserve attention before introducing my own understanding of interpersonal life strategies.

Torbert presents three essential forms of power:

- *unilateral power* - that which is held through position and authority. It is the power of kings where subjects obey without question, and the consequences of not obeying are unquestionable;
- *diplomatic power* - that which is agreed and given freely to others through recognition of the others abilities. It is the power of consent;
- *logistic power* - that which is given to others through laws. It is the power of rights and logic.

He explains very fully these forms of power and in doing so uses illustrations and stories that are familiar in western history; stories of kings, democracy, patriarchy, ethics and western law. This acknowledgement that each form of power is of value within a particular context avoids establishing a hierarchy of power where there is an assumption that one form is more civilised or 'better' than another. At times of crisis and in life threatening situations, unilateral power is appropriate and essential. In situations where agreement is needed in order that actions are owned by participants, then diplomatic power is appropriate. In situations where careful planning is needed to find the most appropriate action, after considering all the information and all possible options, then logistic power is likely to be appropriate and effective. However, situations are not always clear and often it is necessary to consider different perspectives of the same situation.

This is where Torbert (1991) considers Rawl's theory of justice as a way of merging all three levels into a fourth dimension. Torbert applies Rawl's theory to the development of a just and humane society. To do this, moral and developmental frameworks are applied to Rawl's basic principles and the outcome is perceived by Torbert as a form of power that respects the rights of others, is rational, and seeks consent. However, the ability to manage this kind of power relies upon individuals being aware of the possibilities within any given context. From Torbert's point of view this is similar to the awareness needed to develop collaborative inquiry. This seeking out multiple perspectives, purposes and issues, requires the ability to move across different power bases, testing out and deciding which is the most appropriate at any given point within the overall vision and intent.

In moving away from developmental stages and a hierarchy of competencies, it seems that power is viewed as organic, rather than abstract, and part of the development of a life strategy rather than outside it. This requires an integrated, interpersonally competent person who can lead the organisation towards transformation through the timely and appropriate use of different power strategies. The question of how people gain these competencies is expressed by Torbert (1991) thus:

> "How can persons develop toward leadership capabilities that include Plato's awareness of the whole, Rawl's parental awareness of principles, rules, own actions, and effects on others, and the dynamic awareness of - and courage to correct - incongruities among these territories of experience?" (p.42)

This is Torbert's search for the contexts and the experiences that will facilitate each individual to develop this multifaceted state of being in the world. Relating the stages of manager development to a preferred use of power, demonstrates that there is a place in the developing organisation for different power strategies to dominate (in Torbert's terms). It is the ability to frame and reframe that allows the individual to act authentically and congruently. It seems to me that as individuals learn to manage power, so they are able to move between the stages of management development defined by Torbert. This movement between is important, as the appropriate use of power relies on an astute awareness of the situation and the ability to respond in a way that suits the purpose.

The ability to view situations from different perspectives, and intervene across the different power bases, can be found at all levels of the organisation. It is often the way the organisation is structured, and the culture that has been created, that works against collaboration and inquiry. As Torbert found, it is not easy to change one's life strategy if the only tangible rewards are locked into the existing one. From my point of view, it is about the way individuals view situations that releases this multiple understanding, and allows power to be seen as facilitative, rather than controlling. Learning to 'hold power lightly' while responding to the moment, with the long-term goals still in view, is the challenge that confronts all 'would be' transforming leaders wishing to enact this fourth dimension of power.

Transforming power, according to Torbert (1991), is the ability to restructure oneself and so develop new ways of thinking and acting that better 'fit' future possibilities.

> "It can be generated neither by internal motivation alone nor by external pressure or opportunity alone. An exercise of unilateral power can force changes in external behaviour but cannot transform the meaning-making structure of a system." (p. 56)

Transforming meaning-making requires a leadership that encourages mutual responsiveness, where the interplay between people creates the context for innovative thinking and practice. In this situation, transforming leadership invites challenge and inquiry, it does not seek to

dispel the incongruous and chaotic but rather to stay in midst of it until new clarity of purpose is achieved. Torbert's focus is on leadership as central to the transformation of an organisation and most of his case studies have authoritative leadership central to the story. In my experience, very often authoritative leadership is not able work in the midst of chaos and uncertainty. However, individuals who are aware of the facilitating nature of power can bring about a transformation of the organisation and it maybe that the authoritative leader remains unaware of the implications of the change.

Liberating structures can be developed through people of 'like mind' working together to seek out the incongruities between purpose, strategy, behaviour and outcome, and to continuously doubt the existing structures by inviting challenge. A community of inquiry where interpersonal competence is encouraged through self-disclosure, supportiveness, and confrontation, can be nurtured throughout an organisation if a critical mass of people are willing to think, act and inquire in a collaborative way. It would seem logical that a recognised and affirmed leader is in a stronger position to develop this, however it is not entirely necessary. If it were so, then women would rarely be influential in developing liberating structures because authoritative power rarely rests with women in organisations.

I have found Torbert's ideas both challenging and revealing and at times I have struggled to stay with him as he recounts his own informative experiences with his understanding of them. My own experiences come to the fore, and the subsequent 'dialogue' that ensues clouds his essential 'truths' - as the understanding he draws from an experience is some times not in harmony with mine (collaboration needs an ongoing dialogue). However, I have come to realise through questioning this internal dialogue that if I allow Torbert to speak to the masculine in me then a language for developing alternative dialogues in the work place is available to me. The key to Torbert's writings for me is the sense of energy and enthusiasm for learning, interacting, and developing. In this I find a 'kindred spirit'. I realise that I engage more fully with writers who communicate a sense of energy and enthusiasm to seek out the essence of an idea or possibility. This kind of energy is also reflected in the work of Belenky et al (1986), Marshall (1984) and Farrell (1992).

Life Strategies and Gender

In exploring the idea of a life strategy I have found that very simple principles guide how I act in the world. However, the interpersonal strategies I use, particularly at work, are complex and often gendered. My experience as nurse tells me that the nurse's role is centred within the context of caring and consequently draws the feminine into dominance, where intimacy and responsiveness blur the interactions. If however I move towards a collegiate relationship within the context of treating people, power is then more clearly defined between who provides and who receives. This draws the masculine into dominance and I find myself in a more defined relationship. I have always been aware of this juggling of self presentation, between 'being

with' and 'acting on'. However, I have never examined the way I do this or what guides the changes in strategy. This idea of different strategies within different contexts is visited more fully when I discuss Marshall's work below.

Torbert's writings have helped me to clarify the strategies I use within multidisciplinary and organisational contexts. Ironically, this clarity has brought into focus the different interpersonal strategies I use within the intimate contexts of caring and exploring personal experience. Discovering these differences has enabled me be more aware of the need to address the genderedness of any given context and draws on interpersonal strategies that affirm basic principles contained by both. These strategies are in harmony with Torbert's collaborative inquiry and pay attention to the differing perspectives of all concerned. This understanding of holding divergence lightly and moving between gendered perspectives has not been gained easily. My own emergent understanding of gendered life strategies is important to recount before I explore the ideas of others.

As far as I can remember, I have valued being clear and straightforward with regard to intentions and actions. Yet I also acknowledge that there are interactions within a given context that cause me to use strategies that 'hold' and 'safeguard', rather than act in a clear and decisive way. When I consider why this is so I arrive at two possibilities. The first is that intuitively I have responded to cues within the context that alert me to be cautious. The second is that others in this context need to maintain power and control for their own sake, and my responding or questioning in an honest and open way may potentially lead to their loss of face. This dilemma about holding back responses that 'fit' with my own life strategy in favour of maintaining an 'open' relationship with colleagues whose interpersonal strategies differ, has encouraged me to inquire into others ideas about gender, power, and spirituality. It is timely now to explore the writings of others before I turn again to my own life strategies and ways of knowing.

Interpersonal competence and being a woman.

I have always considered myself as assertive and willing to take risks and to question my own beliefs and values. Being assertive has meant that I have learnt techniques that help me suppress negative self doubt and develop clarity about my own and others' rights and responsibilities. This way of functioning is in harmony with Torbert's ideas about interpersonal competence. These strategies can be learned and are effective in helping mutual respect and acceptance when put into practice. Belenky et al (1986) challenged my complacency about 'having arrived' by presenting me with another way of viewing my own way of knowing. Reading about the research experiences of these authors caused me to revisit my own ways of knowing, and in doing this to locate and connect their accounts of differing women's epistemologies with my own experiences. Through this process I began to understand the

journey I have travelled and the tensions I experience in adjusting to the realities of working in a large organisation,.

In reading about the lives and 'voices' of other women I have gained a broader understand of being a nurse in western society. I have become more aware of the intrinsic difficulties nurses have in asserting themselves in a male dominated culture, and why I am more successful at work when I use strategies that are from the masculine part of myself. I am now more circumspect when male colleagues say, "I like it much better when you really get the energy flowing and punch it out!". There is pleasure in this affirmation, but there is also a sense of rejection and denial of my need as a woman to be heard and understood through a dialogue that affirms a more mutually supportive stance. Belenky et al speak to the feminine in me, reaching deeper and more profoundly into my personal self, making connections with my sense of spirituality and my need to be part of and with life. In order to place my own experiences within the context of Belenky et al's work, I will briefly note the work they undertook to uncover the way women gain knowledge. I will relate this to Torbert's ideas and the personal changes Belenky et al experienced as they worked with the women and their stories.

Belenky et al and Torbert were all interested in understanding how students developed their ways of knowing and coping in the world. Torbert's focus is on the development of interpersonal competence and to this end he formulates an understanding of what this means, then creates a context in which this will develop. There is no reference to gender but rather an assumption that the path from one interpersonal strategy to another is common for most students. Belenky et al (1986) take a different point of view, beginning with the premise that students develop in predictable ways but moving to pursue the idea that women gain knowledge and competence in ways that do not necessarily mirror what is known about men.

The rationale for researching the way woman gain knowledge was based on the belief that:

> "our basic assumptions about the nature of truth and the origins of knowledge shape the way we see the world and ourselves as participants in it." (p. 201)

The intent was not to directly influence the learning environment, but to discover why:

> "--women often felt alienated in academic settings and so often expressed doubts about their intellectual competence." (p. 202)

It would seem to me that in the same way that Torbert uncovers the interpersonal strategies of college students, Belenky et al seek to uncover the life strategies of women. Their beginning points are very different, but their vision of what an interpersonally competent group of colleagues might be seems to be very similar.

Belenky et al take a constructivist point of view in understanding the lives of women. In their research, information was collected about the way woman viewed their lives, and from this data

five different perspectives about reality, the nature of truth, knowledge and authority, were extracted. Assumptions were then developed about they way women gain knowledge, and more importantly, how this gaining of knowledge might be nurtured. This understanding of the way women learn led to ideas of life strategies and interpersonal competence.

The research methodology was based on the work of Perry (1970) who constructed a map charting the epistemological development of university students, mainly male. This work was repeated using women students and the results indicated that women move through very similar stages to men. Belenky et al (1986) found this research lacked rigor with regard to the way women perceive themselves and the learning process:

> "While this strategy enabled the researchers to see what women might have in common with men, it was poorly designed to uncover the themes that might be more prominent among women. Our work focuses on what else women might have to say about the development of their minds and on alternative routes that are sketchy or missing in Perry's version." (p. 9)

Thus, this research begins with acknowledging that giving women a voice is important. This openness to direct information arises from the experiences of the writers as they worked with students and colleagues prior to the research. Consequently the researchers entered the research with an understanding of the way some women experienced gaining knowledge, and this influenced the way in which the methodology was implemented. The respondents were asked to talk about what was important about their life and learning, placing the emphasis of the research on hearing the voices of women. 135 women from different ethnic and class backgrounds, different educational and community settings, and different life experiences were interviewed. The data was then analysed in two ways, the first using the encoding system already established by Perry (1970) and then a contextual analysis designed by the authors.

Belenky et al found that Perry's encoding system was unable to do justice to the way women explored their own thinking, consequently the data were regrouped to better match the epistemological perspectives of women's experiences. From this analysis five epistemological perspectives were identified and the characteristics of each were defined. The results of the contextual analysis yielded a wealth of information about the way women experienced and made sense of their lives. It is this presentation of personal experience that illuminates my own.

The life strategies of women

The use of metaphor and story is very familiar and has encouraged me to pay attention to my own ways of knowing. Before I consider my own sense of gaining knowledge and communicating with others, I will outline the ways of knowing Belenky et al identified, then I will describe the ways the women interviewed talked about their lives. Finally, I will consider whether the different ways of knowing experienced by women are linked to developmental

stages (e.g. Torbert, 1987) or are contained and 'complete' within the context of their particular life.

The five epistemological perspectives developed by Belenky et al are:

silence-	A sense of being mindless, voiceless and subject to the whims of external authority.
Received knowledge	These women conceived themselves as capable of receiving and possibly reproducing but not creating knowledge.
subjective knowledge	Truth and knowledge for these women are personal, private and subjectively known or intuited.
Procedural knowledge	These women invest in learning and applying objective procedures in order to obtain and communicate knowledge - both 'separate' and 'connected' knowers are able to use their minds in this way.
Constructed knowledge	These women view all knowledge as contextual experience, see themselves as creators of knowledge, and value both objective and subjective strategies for knowing

The first sense of knowing is almost to not know, silence is experienced as 'mindless, voiceless and subject to the whims of authority'. Although my experiences of this silence are mainly in my past, I still have fleeting times when I am unable to find my voice and feel estranged from the dialogue occurring. The second way of knowing is through received knowledge and in this the woman is able to receive knowledge and to reproduce it. The knowledge is received from some external authority that is 'all knowing', the individual not being able to create knowledge from their own experiences. This way of knowing is not so far from my awareness, as I stumble and doubt what I know from experience in the face of the dominant thinking that presents 'the truth'.

The third way of knowing is subjective knowing and produces an understanding of truth and knowledge that is personal and private. This kind of knowing is often gained through intuition and noticing themes, patterns and repetitions. This is very close to me and I have struggled with bringing it to full consciousness and, more importantly, to the scrutiny of others. I can acknowledge now that this is a valuable way of knowing and needs to be shared if it is to be fully valued. (Re-valuing this way of knowing gave me courage and calmness to develop personal story telling in the fieldwork.)

The fourth way of knowing is procedural knowing and is about formulating a way of making meaning which can be achieved through a process of understanding the other, or gaining knowledge of the other.

"Procedural knowledge is "objective" in the sense of being oriented away from the self - the knower - and toward the object the knower seeks to analyse or understand." (p. 123)

Belenky et al use the terms connected and separate knowing to identify these two very different ways of developing procedural knowing. They borrow these terms from Gilligan (1982) and Lyons (1983) who describe two differing conceptions or experiences of the self. Separate is experienced as essentially autonomous or separate from others; connected is experienced as essentially in relationship to, or connected with others. They take the analysis further and say that those who experience the self as predominantly separate tend to resolve moral dilemmas by appealing to impersonal and generalised systems of justice and rights. Those who experience the self as predominantly connected tend to resolve such dilemmas based on notions of care and responsibility.

Similarly, Belenky et al conceive of two epistemological orientations with regard to the moral position of each perspective. They describe a separate epistemology as being based upon impersonal procedures for establishing truth, where as a connected epistemology views truth as emerging through care. However, in defining separate and connected knowing, they refer to the relationship between the knower and the objects/subjects of knowing, where the latter may or may not be persons. Therefore, the focus of their study becomes the relationship between the knower and the realm of ideas. Separate knowers emphasise objective 'truth' and seek mastery and control of ideas by taking an adversarial stance and playing the 'Doubting Game.' On the other hand, Connected knowers develop procedures that include collaborative relationships, an active surrender of authority, the use of narrative, and play the 'Believing Game' to achieve this.

In summary:

"Separate knowers learn through explicit formal instruction how to adopt a different lens - how, for example, to think like a sociologist. Connected knowers learn through empathy. Both learn to get out from behind their own eyes and use a different lens, in the one case the lens of a discipline, in the other the lens of another person." (p. 115)

Finally there is constructed knowing where women learn that knowledge is constructed from the contextual experiences co-created with others. They learn that they are the creators of knowledge and value both subjective and objective strategies for achieving this. Women come to understand constructed knowing through the two different pathways of separate and connected knowing. Both groups look beyond limited compartments, and advance their understanding of how all knowledge is constructed.

"It is in the process of sorting out the pieces of the self, and of searching for a unique and authentic voice, that women come to the basic insights of constructivist thought: *All knowledge is constructed, and the knower is an intimate part of the known.* ..... Ultimately

constructivists understand that answers to all questions vary depending on the context in which they are asked and on the frame of reference of the person doing the asking." (p.137)

It seems to me that constructed knowers, whether favouring a separate or connected knowing stance, are able to seek knowledge from both perspectives. However, each person has their own unique way of interacting with the world and will have developed a preference for engaging with ideas and co-creating knowledge. The question of whether gaining knowledge is achieved through defined stages of development was explored by Belenky et al, but no conclusion was reached. The idea that separate and connected knowing may be gender specific, was considered and it was recognised that women were more likely to be connected knowers. However, no evidence to this effect could be extracted from the research because the research subjects were all women. I identify myself as coming from predominantly a connected knowing stance and I lean towards a caring frame in my transactions in the world.

My recent experiences and past memories tell I that I carry all the ways of knowing identified through this research. I can still feel silenced in situations where others are assuming a position of dominance through authoritative power and when I see no useful purpose in challenging these situations. There are certain situations where I use received knowledge in order to move away from issues that are of little consequence from my point of view. There are also times when I revisit my subjective knowing and become once again tuned in to my 'wilder self'. It is in my subjective knowing that I can engage my sense of the world and feel passionate about ideas and issues.

However, in the main I am a connected knower. I have many ways of accounting for this and I will do so when I tell my own stories of my research experiences. Suffice to say, now that I have learnt to stand in other's shoes, to understand their ways of being in the world, this is now a part of who I am. This does not mean that I never function as a separate knower. I do, at times very actively, particularly when decisions are being contemplated that will create more problems than they will solve. At these times I am very able to debate the issues and validate my own understanding.

Gaining knowledge, valuing experience, and living with the memories of past encounters is all of value, as is the ability to develop frameworks and test out hypotheses. There is something about knowing that both releases and binds - once choices exist one cannot choose blindly. The struggle I have had to write this thesis has been about knowing who I am and making choices. Both Torbert (1981) and Belenky et al (1986) are concerned with how people learn to develop self worth and interpersonal competence. I have found that both have an approach that is compatible with the way I experience my own interactions with others. Torbert has developed a schema that aims to uncover and provide an option to the mystery/mastery interpersonal strategy. Belenky et al entered into the thinking of women in order to understand

the ways of knowing that encourage a sense of personal worth. My view is that each travels on a different pathway to reach an understanding of interpersonal life strategies, although their goals seem to be similar. My path has been more akin to that described by Belenky et al, and I intend to present a summary of this journey before I consider the issues of gendered life strategies.

I have always had an inquiring mind and consequently I have always been interested in the way people learn. When I began to read 'Women's Way of Knowing' I assumed that I would be reading about 'other women', not about me. I viewed myself as quite assertive and able to confront issues, although I knew I had developed strategies that were a bit different from other people. It was not long before I became aware that not only was I like many other women in the way I thought, but I had actually experienced the impotency of knowing that the 'truth' is held by others more powerful than me. At each stage of knowing I could identify with the person I was, and the person I am, as the anxiety and tensions were re-experienced. However, I could also recall clearly the people and experiences that had helped me find my own path to new ways of knowing.

The impact of reading about how women learn, and about the power of patriarchy in controlling women's minds, opened another dimension of my working life and released an urgency to be myself. This process of recognition and affirmation also faced me with a conflict about integrity and congruency between thinking and acting. It would seem from reading the authors' reflections that they also changed and developed as a result of their experience of researching together. I found this acknowledgement mirrored the changes I have made as I discover new ways of understanding myself and others.

Belenky et al, in exploring women's voice through interview, discuss the way women need to overcome a multitude of obstacles to develop the power of their minds. One of the ways to achieve this 'power of mind' is to ensure that the way in which women receive their education honours the way they naturally learn. This idea of congruence between gaining knowledge and ways of learning caused me to reflect on the way I facilitated the research group, and on my own learning preferences. I also realised that attending to the way women learn does not exclude men, particularly men whose work encourages feminine ways of being and interacting. Learning is about experiencing the world and although the context in which learning takes place is important, gender issues will always present another dimension and create different possibilities.

In reality, I have found it impossible to keep gendered ways of interacting mutually exclusive. Although one may be dominant in a particular context, the other is always present. My own vision and purpose in life and sense of spirituality transcends my occupation as a nurse - being myself is much more than being a nurse. My search for congruity and integrity as I develop my sense of self, and the patterns and pressures that make sense and bring both joy and pain,

are the essence of my being. The value of rewriting my own history, noticing the repetition in different forms, recalling the stories that keep experience alive and available, all these ways of interacting keep me in touch with my sense of being. In all this I am aware of the interweaving of my feminine and masculine self, and I have found a clearer analysis of this through reading about others' journeys. Marshall's (1984) book 'Women Managers: Travellers in a male world' opened up another dimension that had been lingering at a subliminal level. It became clear as I worked through the field work, paying attention to my own external and internal experience, that I sometimes struggled to accept what I considered to be the masculine side of my nature.

Expressing the masculine and feminine.

I began to read about Bakan's concepts of 'agency' and 'communion' (in Marshall, 1984) when I was struggling to understand why I chose to respond to some situations in a very logical purposeful manner and others in a searching, responsive, inclusive manner. It seemed to me that my choice was not about different kinds of problems but more about the people involved and the contextual relationships. I was aware of the gender balance within myself being tipped in favour of one or the other, but I was not clear about why or what the process meant for me. Torbert and Belenky et al, in their separate ways speaks, to either the masculine or feminine in me. Marshall speaks to my need for balance and integration between these two ways of interacting in the world.

This searching for balance and internal integration has led me to follow Marshall's journey from exploring the ideas of feminists, to creating another way of presenting the power that belongs to women. It is in the middle of this journey that I gained a sense of balance between my own masculine and feminine. Marshall's development of the ideas about agency and communion, and the possibility of balance, provided me with a connection and a counter-balancing between the two.

Marshall, in searching out the masculine and feminine ways of acting in the word, refers to Bakan's concepts of agency and communion. Agency being:

> "the expression of independence through self-protection, self-assertion and self-expansion; communion the sense of being 'at one' with other organisms." (p.64)

Marshall goes on to say that the agentic strategy's main aim is to reduce tension by changing the world about it. By contrast, communion seeks union and co-operation as its way of coming to terms with uncertainty.

> "Whilst agency manifests itself in focus, closedness and separation, communion is characterised by contrast, openness and union." (p. 65)

Agency and communion are seen as two life strategies that are markedly different in the way they are experienced. Agency is a sequence of stages that allow the individual to manage the

anxieties of interacting in the world, and is centred on the need to control and stabilise the environment. Communion, on the other hand, is quite different. The focus of communion is on union, wholeness, the recognition of patterns and the importance of context. Marshall expands and provides depth to these concepts by providing another dimension, one that feels familiar but requires careful thought. My immediate sense of resonance gave way to surprise as I identified with Marshall's idea that:

> "Communion incorporates an expectation of change - to the self, situation or context - as inevitable. Acceptance means that change is toned neither excessively positively, or negatively - it just is." (p.69)

In pursuing the connections with my own thinking and doing, I realised that writing this thesis has taken me to the point of disintegration in my desire to express my feminine self. The strategies of communion:

> "....make it open to penetration flooding and eventual destruction by contextual forces ..... its attributes of success are also context-dependent'. (p. 69)

Marshall talks about the way in which a successful life strategy might be developed by 'mitigating agency with communion' and through 'communion enhanced by agency'. This echoes the discourse in my head between Torbert's ideas about unlearning mystery-mastery strategy in order to learn interpersonal competence, and Belenky et al's statement of concern about imposing the doubting model on women (or men for that matter).

> "Doubts imposed from outside seems at best redundant and at worst destructive, confirming the women's own sense of themselves as inadequate knowers. The doubting model then may be peculiarly inappropriate for women, although we are not convinced that it is appropriate for men either." (p. 227)

Marshall takes it further and provides me with a multifaceted way of managing gender within myself, by exposing the energy that each contributes. Working with these ideas has not only given me a way through the impasse when the two energies are in conflict within me, but also when I experience this clash in live situations where I must choose how I present myself. These ways of understanding the expressions and driving energies of gender have given me an analysis and a thoroughness in reflection. However, when I reflect on my own life strategies and the choices I make, Marshall's following statement resonates with my own experiences.

> "Women maintain society through physical and emotional nurturing, often at the expense of their personal needs for independence. In doing so they tap a base of truth which values interdependence, and respects personal skills for achieving it." (p.74)

In recognising this truth as essential to my way of being, I can also recognise the way I have woven into this core concept:

- a way of balancing my own ways of expressing gender;
- a degree of clarity about what I am perceiving, receiving and internally creating in any one context;
- a heightened awareness about valuing the parts and the wholeness of myself and others, particularly in relationship to gender energies.

Having now reached an understanding of my own interpersonal life strategy, there remains a part of my journey that begs to be acknowledged. It is about my sense of spirituality that I always assumed was a part of being a woman. I am able to recognise parts of my spiritual self in images that are not feminine. Thinking and researching ideas of feminine and masculine has given me a different sense of how the two aspects can co-exist and intertwine. I no longer deny spirituality expressed in the masculine form. Mythology that is patriarchal provides me with a sense of union with the warrior women (Bolen, 1992) and I can make sense of the forces of good and evil and the role of gender in finding a balance (Eisler, 1987). I can now hold competing images and ideas lightly rather than rail against one or the other.

I am aware that the images women use to express spirituality are closely connected with the reclaiming of the feminine in society. Starhawk (1989) expresses a sense of belonging and beginning through the cycles of life, providing an underlying metaphor that moves us to take action to express our aliveness. This sense of spirituality is strongly of nature, and like other feminist writers, Starhawk sees this as the goddess-immanent embodied in the living world, and all that the world entails.

> "Immanence challenges our sense of values. When the sacred is immanent, each being has a value that is inherent, that cannot be diminished, rated or ranked, that does not have to be earned or granted." (p. 177)

This immanence is perceived as 'an ache or power from within', creating the personal power to realise our potential in the world. This is an image I have held for most of my adult life, and like Starhawk, I acknowledge that this personal power is not reaped without return. To be 'at one with the world' requires that this power is grounded through 'returning something of ourselves to the world.' This sense of a reciprocity is embedded in my life strategy as I seek to achieve this kind of balance.

Starhawk talks of the 'power within' much as a seed has the power to grow and mature, so an individual can gain power without diminishing another's power. As I write this, I find myself considering how my own sense of spirituality has changed frame. At first reading I understood through my feminine muted self, but now I am able to recognise my masculine self and to begin to address the energy that engages with the power within myself and others. It has

been through feeling compassion for the powerlessness of both men and women as they struggle to find the 'power within' that this new framing has become clear to me.

Colgrave (1979) also confronts the ways in which we separate ourselves in gender opposites and in so doing become alienated from ourselves. Colgrave considers that the aim must be one of striving towards androgyny in order to be to be truly 'at one' with ourselves.

> "Just as the union of the physical male and female is described as making love, so the union of the masculine and feminine principles within the psyche allows for an inner experience of love which is the hallmark of the androgynous consciousness." (p.98)

This sense of inner wholeness liberates the individual to love others for what they are, because we are no longer searching for the aspects of ourselves that we cannot develop. This sense of being whole in terms of the individual, the world, and all that flows between, appears to be a state without boundaries. For me, it is about the nature of each personal event and is intricately linked with who I am when I am 'being a nurse' .

Nursing, I believe, encapsulates many of the concepts and conflicts associated with the gender struggles that I have explored. As the fieldwork unfolded, I began to recognise that the way nurses make sense and take authority over their work, and through their work, expresses their own lives. Each of us took time to review our own personal lives as we explored our lives as nurses. This exploration created a shared sense of knowing about nursing and being a nurse. However it was in the second cycle of research that ways of knowing about ourselves and our work were explored, and through that our life strategies became apparent.

In the next chapter I will first consider storytelling as a method for understanding personal experience, and then I will revisit the second cycle of research and describe the patterns that emerged as we worked together.

Chapter Eleven

Storytelling as methodology

When I first received the challenge from my supervisors (during a supervision session) to find some rationale for the use of story telling, I felt attacked. Stories were a part of my personal and working life, they were very much a part of me and I did not consider they needed justifying. I had never considered story telling as a research methodology with its own form of rigour, so consequently I was unaware of the possibilities in the challenge. I also remember feeling overwhelmed by the idea that the methodologies I had researched and used to manage the fieldwork so far might need to be reconsidered because of the way the research journey had emerged. However, I took up the challenge and began the process of locating appropriate literature and reviewing the field work data.

I began with autobiographical accounts of people's lives, some of which relied on historical data, others researched through live interviews. Much of this reading had a feminist perspective and, although this was interesting, it did not fit with the approach I had taken so far. I searched for a method that contained both the personal stories I tell of my life and the stories that emerged as we worked together. I also realised that most of these stories already existed in the field work notes, letters, journals, and for the first cycle, audio tapes, and that these had arisen out of a particular context. These 'knowns' about story and context narrowed my field of vision.

After much reading and pondering about how to take this agenda forward, I gradually formulated the question:

> "Can I do justice to the agreed research purposes and methods in writing up the research cycles and caste a more enlightened eye on the data, honouring the stories that produced them?"

This question acted as guide for me to select sources that might provide another framing, allowing me to analyse the stories that were told without devaluing the methodologies we had used so far. With this in mind I considered the way stories had emerged and came to the conclusion that the stories we told were about our nursing lives and these stories had emerged within the group context. Therefore, my task was to find a way of presenting these stories that recognised the group process we had developed as well as our lives as nurses. Within these criteria I located two research articles, one giving an account of working with a group of women researching equal opportunity issues, the other providing some clarity about the relationship between the telling of a life story and context in which it is told.

These two articles provided the theoretical and experiential accounts I needed to see the path ahead. I will begin with the article by Farrell (1992), because the research reported on is undertaken within a group context and therefore has some resonance with our work as peers. I will then follow with the work of Mann (1992) in order to clarify the nature of life stories.

Finally, I will conclude with Clandinin and Connolly's (1994) 'Personal Experience Methods' which provided me with a way of moving from the stories that emerged in the field work towards writing a research account of these personal experiences. In doing this I will focus on the authors' use of story to understand personal experience.

Researching in small groups

Farrell (1992) was involved in researching women's lives through writing biographies that gave account of both work and personal experiences. These biographies were then used as case studies to create training material for:

- women's personal and career development;
- teaching specific skills - interpersonal, strategic planning etc.;
- encouraging equal opportunities.

However, for the most part, the women involved in telling their stories found the experience liberating, enabling them to clarify issues and gain insights into their lives. Farrell emphasises the value of telling one's own story -

> "It is this telling and retelling of stories that we as women share our insights and viewpoints, learning about ourselves, our culture and each other." (p. 218)

Although the main intention of developing these case studies was to provide training material, other information was extracted by looking for issues and themes. For example, for all the women in the research, personal and work lives were intricately entwined and gender issues were present in all cases, either in explicit or implicit forms.

Farrell then takes the biographical perspective further, and discusses how life stories are part of her work with equal opportunities groups. These groups are aimed at creating a learning environment that encourages women to value themselves as individuals through telling their stories and listening to others. In discussing the appropriateness of this method, Farrell notes that the 'oral tradition' is a part of women's lives in all cultures:

> "For centuries the telling of stories and sharing of experiences has been women's way of keeping alive their various cultures and traditions, the oldest of all being the oral tradition. This not only keeps alive the culture, but is a way of learning about the reality of each others lives." (p. 216)

In a peer group such as the one we developed, critical incidents and issues were expressed in stories, and inquiry into the issue or the experiences emerged. This is coherent with Farrell's understanding that :

> " ..... in equal opportunities, the telling of life stories, the putting out of personal experiences, telling it 'how it is' and listening to each other is the cornerstone of the way I work." (p. 218)

Farrell also acknowledges that asking women to share their life stories is a way of encouraging them to speak out, and so break the invisibility barrier where women are contained within the 'appropriate behaviour' -

> "..... we are expected to be, and trained to see ourselves, in support roles, a strand of our conditioning which comes largely from our nurturing and caring roles in the family, as wives, mothers, daughters, sisters." (p. 220)

For nurses this is doubly so, caring for others extends across both personal and professional roles. It is role expectation that creates the 'invisibility barrier' for nurses and places them peripheral to the 'real work' of the organisation. Nurses are often absent when decisions are made that affect their working lives, consequently they feel powerless to take charge of their own work unless it is of a 'hidden' kind of caring with another.

Farrell takes a proactive role and highlights the issues of powerlessness, gender and the value of work as a means of raising awareness of inequalities at work. I found these issues emerged in both the first and second research cycle. However, I did not take a proactive consciousness raising role - inquiring, discussing and encouraging possible ways of taking action in the work place were the strategies we used. In the second cycle I did offer different 'frames' that might help make sense. However, these were not robustly given but rather presented as 'another possibility' - e.g. 'interpersonal competence', 'research as praxis' or 'women's ways of knowing'.

The way we worked together as a group achieved the kind of connectedness that Farrell seemed to consider important in creating a learning environment. The way stories emerged and became the focus for discussion and understanding each other's lives has an affinity with the way Farrell describes equal opportunity groups. My understanding now is that story telling and self discovery is a natural part of groups where the individual's personal experience is valued and their telling of it encouraged. It is clear to me now that the group process we developed to create inquiry was also an appropriate context for eliciting life stories. The next step is to consider the ways in which stories are representations of personal experience and therefore a valid way of exploring our lives as nurses.

Life stories as a research method

Mann (1992) explores the use of life story as a research method from three points of view:

- What is a life?
- the relationship between the researcher the subject and the life as told;
- the experience of telling a life story to a researcher.

Mann considers the nature of a life story and in so doing comes to the conclusion that a life story is that part of a life history told to another.

> " .... the life story approach attempts to represent the experiential truth of the life lived. That is, to give expression to the person's own story, as they tell it, of their lived experience." (p. 272)

However, the telling of a life becomes a process engaging the minds and the 'here and now' experience of both the story teller and the researcher/s. The telling takes place as each engages with the other and is governed by both language and social context. How I, as researcher, make sense of another's story will not be the same as the understanding the story teller has of this same story.

> " .... a life story can never be a record of what happened, only ever an expression, interpretation and reinterpretation of the 'phenomenological stream of consciousness' and the 'interactional stream of experience'." (p. 273)

Within this setting the story that emerges is as much responsive to the context in which it is told as it is to the original experience.

I can remember telling my life story during the first cycle of research, and also telling the same story during a research group meeting with fellow students and supervisors. These two experiences were very different for me, the first elicited a high degree of enthusiasm and inquiry, the second elicited puzzlement and a sense of distance. My experience tells me that the context in which stories are told has an influence on the way that story is experienced. My conclusion from my second experience, rightly or wrongly, was that life stories were not an appropriate way of communicating within this research group meeting.

In accepting that stories are told from the perspective of the individual's life, it would seem reasonable to assume that each individual's life strategy for coping with life's stresses is contained within them. Mann (1992) also considers the question of whether men and women tell different stories about their lives. Her conclusions are based on studies that suggest men are more likely to use a linear narrative structure and women a more global one.

The possibility that society affirms certain narrative forms for telling a life story places some control on the way a story teller might tell their story, however, Mann provides another point of view. It is possible, she says, for people to chose different narrative forms in accordance with the social context operating at the time. The choices people make when they tell stories of their lives are influenced by:

- the need to provide a coherent account of our lives;
- the specific social context of the narration and the conventions of narrative structure;
- the specific cultural context (for example gender) and the scripts available that are seen to be appropriate to express and interpret the particular individual's life;
- the individual's particular life experience;
- the particular time in a life that a life is told.

Reflecting on these influences now, I realise that at no point in the research journey did I intend to gather all the information about each individual's life. The choice about what was disclosed lay with the story teller. In truth I did not go into the research to gain accounts of individual's lives. Personal and work stories emerged in the first cycle and work based stories

became central to the second cycle. However, I accept that the use of story to represent experience was clearly influenced by the context and our expectations of our lives as nurses. The particular time in our lives did not seem to be as important as the context in which the story was embedded.

The need to provide a coherent account of our research experiences in the second cycle was sometimes a struggle, our understandings of our own experiences were often unsure and unclear. Perhaps Mann's perspective on the way we create our own stories speaks to this:

> "Like a playwright we may construct a dramatic narrative of our lives in order to make sense of life. We include critical scenes which are told according to certain unconscious rules and scripts about what is appropriate in a life." (p. 274)

This touches on my internal struggle about the individualness of a life and the connectedness of living, and consequently the stories that I tell myself and others. Having very briefly grounded the way in which I intend to relate to stories as personal experience, I will now turn to questions about how I as a researcher explore these personal experiences and create a research account.

Personal experience methods and story telling

In making clear the value of story in understanding another's life, Clandinin and Connelly (1994) opened to me the possibility of using story telling as methodology for understanding the experiences we shared as nurses.

> "Story is ..... neither raw sensation nor cultural form; it is both and neither. In effect, stories are the closest we can come to experience as we and others tell of our experience. A story has a sense of being full, a sense of coming out of a personal and social history." (p. 415)

In identifying stories as data for researching personal experience Clandinin and Connelly go further and state:

> "With this as our standpoint we have a point of reference, a life and ground to stand on, for both imagining what experience is and imagining how it might be studied, and represented in researchers' texts. Experience in this view, is the stories people live. People live stories, and in the telling of them reaffirm them, modify them, and create new ones.' (p.415)

This then provides the basis for treating stories as data and presenting the research text in a way that honours the story and the author/s life. Clandinin and Connelly give a full account of the use of narrative and make clear the importance of separating phenomenon from the research inquiry.

> "Narrative names the structured quality of experience to be studied, and it names the patterns of inquiry for its study. To preserve this we use the reasonably well-established

> device of calling the phenomenon story and the inquiry narrative. Thus we say that people lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience." (p. 416)

Within this statement are key issues that speak to the way story and narrative are interwoven to create the research text. The value of story as a way of understanding personal experience is clear. How field work records are developed from the stories told, and then transformed into the research text, is a little more complicated. Clandinin and Connelly arrive at a framework for managing the complexity of this kind of research. They provide three sets of methodological questions, which in brief are:

- The role the researcher takes within the field of research experience;
- The texts told and written that the researcher will use to represent, reconstruct and interpret the research experience;
- the effect of the autobiographical presence in field and in the text, and consequently the research account.

I will now address each of these issues with reference to the way I set up and managed the first and second field work group, and with reference to what I need to consider when I revisit the field work data and create another view of the experience.

The role of the researcher in the field

The field of research includes my work place and the field work groups established during the first and second research cycle. In both contexts I took account of my role as subject and researcher. Thus, I am able to tell of my personal experiences, particularly in the work place, and write a research account our work together in the group. In the first group I took facilitator role and all members of this group were fully aware that I would be writing a research account of our experiences together. In the second group I took a different role because facilitation and management of the group was shared and stories became central to the way we presented our work experiences. My personal research journey became a part of my contribution to our discussions as I presented ideas about life strategies together with the writings of other nurse researchers. In essence I was a participant researcher or, in Co-operative Inquiry terms, a co-researcher/co-subject.

The texts told and written

In the first research cycle data were collected through taped recordings and I have given an account of how this information, together with other accounts, was used to create the research text. In my first account of this second cycle I provided an outline of the information available to me and to each person as they worked within the framework of their research. This information remains available to me through records, letters and personal contacts. I intend to revisit this data from a perspective that affirms the stories that were told.

The effects of my autobiographical presence

I have already mentioned my contributions to the group through the literature I was reading at that time and how this provided a different perspective and new possibilities. I also searched my own personal experiences as particular areas of practice were discussed and, where appropriate, I contributed from these. My mind was always alert to connections, possibilities and the relationship between the 'here and now' and the ideas developing in my head. It is possible that others were doing the same, however my tentative inquiries about some of my thinking did not create a desire to explore within my peer group. My attention was primarily on understanding the experiences of my peers and finding resonance with my own. Consequently I did not present a story from my own practice, rather, I presented incidents and partial stories as they seemed to 'fit' with others' experiences.

A sense of watching, timing and letting issues emerge was a part of my behaviour in this group. Whether this is my personal style or learnt strategy I will leave for later to explore. Being a researcher with a thesis to write must have some influence - reading, thinking and exploring ideas certainly did. I consider that during the group work I was aware of the possibilities that I might overly influence the process, so to this end I possibly let patterns emerge more than I might have in different circumstances. This I will never know.

The Way Forward

It seems to me now that the research methodology I chose to use at the beginning of the field work provided a context for stories to emerge and become an important part of the research data. However, when I searched the data for themes, issues and new understandings I managed to filter out both the actual stories and the personal experiences of the story teller. Re-examining the data required that I first consider what I had filtered out and then to search the data and identify each story and how they might interconnect. This process provided a different perspective, one that paid attention to the stories told and which 'spoke' to the life strategy of the story tellers.

Thus my intention in writing a second account is twofold:

- To elucidate the patterns that emerged as stories were told and as we shared our life strategies;
- To keep faith with work we achieved as a Co-operative Inquiry group and, within this, our experiences as co-researchers and co-subjects.

Thus the lens of story telling provides a richer picture of how we worked together as a group, and how this shifted the way I interpret the field work texts. So in writing this second account, story telling becomes a method for representing personal experience. The records I and others collected and shared become the field work texts, and the process of reviewing, interpreting, testing out and creating my own sense of journey produced this research account. In revisiting the second research cycle I have used Mann's work particularly as a point of reference and to guide the use of story telling as personal experience. The following

statements from Mann (1992) seem to hold this process in a way that facilitates sense making of this experience.

> "Lives are expressed in narrative and narrative informs the life, the living of a life creates a new narrative and the only expression of a life is a narrative." (p.275)
>
> "I cannot separate life from narrative and narrative from life." (p. 275)

Revisiting the Second Cycle of Research

At the beginning of this cycle of research we decided not use tape recorders during the group session, but to keep reflective diaries. We agreed to record our experiences in the group and the work place, and to use these writings to share and develop ideas. I did not consider the absence of audio tape recordings as a problem. I felt confident that all the data I needed would be available to me through my own and others' records.

> (Going with a situation and trusting that what emerges is of value and is sometimes 'more than one might have anticipated' is a familiar strand of my life strategy.)

This freedom to explore my own and others' experiences provided me with the time and the opportunity to be more fully present in the group. Within this context I became aware of the patterns of interaction that emerged as stories were told, and people responded to both the story and the person.

Story became the focus in the second cycle of research because we allowed a different process to evolve. This difference was partly due to the way the whole research process evolved and developed, and partly because we decided to reach into our experiences as nurses and share them as a peers. In the first research cycle the focus of our attention was on an issue or an incident, and group members contributed intermittently around the topic. In the second group the focus remained with one person's experience. When there was a consensus to move on, or the person concern made clear they had were ready to close the discussion, then the focus would move from one person to another. Consequently the interactions were more intense as members joined the story teller and contributed their own experience. However, this only occurred when the story teller encouraged a contribution, or affirmed a suggestion or request.

> (I am aware now that the real change was the depth of inquiry that encouraged this intensity of engagement.)

The process of achieving this collaboration was one of listening to the full story, then inquiring. The interactions were always tentative to begin with, often affirming, sometimes looking for consequences, or speculating on what might happen. As a story unfolded and a picture became clearer, we offered alternative viewpoints and sometimes possible strategies. Rarely did the person in the centre of the discussion make a clear decision to act and there were no pressures for resolution or action. The interactive process sometimes clarified the story for the story teller, sometimes embellished it, and sometimes created other stories that linked and

created some sense of harmony. The process remained very open, although the intensity of the experience was very apparent to us all. There was an unspoken acceptance that taking care of the individual allowed each person to make sense of their own situation. I found it supportive, inquiring, and respectful of each person's life strategy.

It was working together around one person's personal experience that encouraged me to revisit the first research cycle in order to investigate the questions that remained with me. This revisiting opened my eyes to a different perspective, allowing me to elaborate and enrich my original understandings and test out the credibility of my own sense making. The conflict that occurred throughout the first cycle and came to the surface in the final meeting is one such experience where I developed an alternative construction. My account of it is presented in Chapter 12.

It is interesting to note that although at the time I was not considering story as methodology, I did explore within the group the idea of revisiting personal experiences. I shared my intention to revisit the conflict that emerged during the first research cycle and as I gained another perspective I shared my sense-making of it. Others in the group were also able to rewrite personal experiences from the past in ways that were liberating. Before I begin to write about the telling of stories I will reflect back to the ideas of Clandinin and Connelly (1994) to identify what constitutes a 'good story'.

What is a 'Good Story'.

> "--methods for the study of personal experience are simultaneously focused in four directions: inward and outward, backward and forward.....to experience an experience is to experience it simultaneously in these four ways and to ask questions pointing each way." (p. 417)

These four directions briefly put are:

- the internal conditions of feelings, ideas, memories and moral constructs;
- the external conditions of environment and culturally defined reality;
- the movement backward and forward refers to temporality - past, present and future.

I intend to pay attention to these four directions as I write about the stories that were told in this second research cycle and about my own stories in Chapter 12. The nature of my autobiographical presence includes:

- my role as participant and researcher within the group and the work place;
- how I made sense of these experiences and managed the field work texts;
- my understandings now as I write this account.

I will make reference to these aspects as I write this chapter and draw my conclusions at the end

How stories came to be told

It seems to me now that story telling emerged as a way of working together because each individual was able to claim time to tell of a particular experience and for others to respect that experience as unique to the teller. My role in this was twofold: I participated as a colleague and peer; and after each session I recorded my observations, understandings and personal reflections. When the time came to begin the research account I met with some of my peers to test the sense I had made of some of the issues we pursued. All the accounts of the group meetings in the first cycle were tested out in this way, and most of my field work texts developed during the second cycle were discussed with the people concerned. In this way I built up a fuller picture of the experiences we shared. The account that I now present was developed in this way.

Stories told and 'spoken in another voice'

Each person, in their own way, spoke of their experiences as a practising senior nurse. Some told stories that were full and detailed, while others spoke of needing space and time to think and dialogue with others. The way I have managed this difference in style and need is to group the stories into those that engaged the group in some careful and solid work, and those that were 'spoken in another voice'. I will begin with those stories that were openly offered to the group. My aim in selecting and writing about these stories is to mirror the way each unfolded and engaged others in discourse.

To achieve this I will present four of the stories in shortened form. In each I will focus on the way the story emerged and how others became engaged in the process. I will then present one full story as the 'centre piece' to capture the way issues and themes are to be found embedded in the stories told. This flow of ideas and experience is the focus for making sense of this second research cycle. It illustrates way the central story is 'linked' with the 'voices' of other story tellers and with my own presence in the field. To make this pattern of experiences and interactions available to you the reader, an analogical representation in graphic form is included at the end of this chapter.

The central Story

Jane's story is chosen as the central story for two reasons:

- because Jane began her story in the second meeting and it continued to unfold as the research cycle progress;
- it contained issues about personal integrity, working with other disciplines and the centrality of caring.

Before I begin to present the way different people told their stories, it is important to reflect back to the first account of this second cycle where I described in some detail the research activities each person pursued. In doing this I gave a brief description of teach person's work setting, the accounts they gave of their research experiences, and the ways in which they engaged within the research field. This provided you, the reader, with the content matter and

some ideas about the path each person travelled. I will now give my account of the stories that were told within the same group context.

Telling and developing stories: evoking, enriching, and elaborating.

Five people presented experiences in story form with the remaining three, including myself, enhancing or adding another dimension to these stories. Each person, in presenting a particular aspect of their research in story form, also surfaced their own life strategies. In life strategy I refer to favoured ways of acting in the world - the ways of knowing and presenting self that limit, or liberate, in times of change and challenge. My intention now is to give a brief account of each story and the responses each story evoked from others.

Colin told a story about his experiences of encouraging inexperienced staff to take part in developing innovative ways of working with very difficult clients. In telling this story Colin expressed his feelings of frustration, doubt and enthusiasm about working with this particular group of clients. His expressed need was to develop a team that shared responsibility and decision making, but his sense of what was 'right' to do with these clients got in the way of allowing others to try out their ideas and possibly make mistakes.

This disjunction between having a clear vision of what might be and seeing no way of meeting or achieving it was the focus that Colin and other members of the group explored from various vantage points. Relationships with authority figures (particularly doctors), being fair to others, the anxieties about delegating tasks, and the satisfaction of knowing what you are good at were all aspects of Colin's story and evoked other's experiences. Eventually Colin focused on the tension between his role as an experienced nurse and the role of the junior doctor who had just arrived for six months duration (a part of the junior doctor training). It seemed this was a pattern that repeated itself each time a new doctor began working with this group of clients. Colin decided to pay attention to this conflict because it had an effect on his credibility with his staff and his own sense of competence. Role expectations and teaching other disciplines were some of the issues we explored at this time.

Eve Took a long time to tell her story. It was painful experience that seemed to touch each one of us. Eve told the story in 'chunks', beginning with an episode where her staff in a maternity unit had failed to check emergency supplies which caused a minor panic. Eve related how she had found the absence of functioning equipment and had immediately 'gone out of her way' to put it right. As a result of her quick actions the situation was retrieved and no damage was done. However, when she next met with the staff concerned, she became annoyed with their lack of concern and as a consequence she lost her temper and the senior midwife dissolved into tears.

In telling this story it was clear to me that Eve did not approve of her own behaviour and requested ideas and understandings from us as a group. We explored with Eve why this kind of situation had arisen and found that Eve was experiencing a struggle between the structural changes occurring in her own workplace and maintaining good working relationships with her

staff. The stress, and sense of urgency, was about losing valued relationships and not having the words or the personal strategies to manage anxieties, fears, outrage and hurt. We gradually learned that the key to these very personal feelings was the loss of her liaison role with a local General Practitioners' group. She explained how the General Practitioners had appointed her to the role sometime ago. This role, she said, gave her a sense of being central to what was happening in the locality, a feeling of being needed. The way this role had been taken from her was the outrage. Without consultation or discussion she had received a letter from the Chief Executive informing her of the change.

This story evoked a range of responses. Some members of the group were familiar with the general situation and offered their perspective. Others had experienced the loss of control that sometimes happens when one is stressed and anxious, and they shared this together with their ways of coping. I offered a way of 'breaking the ice' with the staff who had inadvertently caused a minor crises and now possibly felt offended by the intensity of Eve's criticism. Most of all we listened to Eve talk about her life as nurse, what she valued, and what she had achieved. Implicit in this story was a feeling of sadness and loss. A year after we completed the second cycle of research Eve took early retirement.

Carol told a story that had a theme similar to Eve's. It was about being demoralised and alienated through a process of imposed changes. However, Carol chose to move away from her own distress and focus on the frustrations and outrage of students. These students, according to Carol, felt disregarded and forgotten as the changes in nursing education became a reality and they were left to complete their course with few resources or support. Carol gave examples of meetings with students that highlighted the unfairness, powerlessness, and lack of perceived opportunities for both the students and their tutors to gain self esteem.

There were several aspects of Carol's story that engaged others. Firstly, the need to find a way of addressing this negative experience. This held our minds for some time and several of us made references to experiences of coming to terms with the inevitable while keeping our own integrity. There was also a tentative inquiry into the relationship between these and Carol's experiences, and whether they echoed her position in any way. This led to a general concern about caring for others in an uncaring environment, and raised the question - "How long can one remain silent in such situations without losing credibility?" This story held our attention for some time as each one of us was experiencing changes that had the potential to disadvantage some people.

Mary did not ask for time to tell her story, however it is included here because it became woven into other's stories. Mary began by offering her ideas about the interpersonal skills nurses need to ensure patients and their relatives had respect and were cared for. With encouragement Mary told us about her intentions to create a patient centred focus to all the activities in her ward. We then explored with Mary what it was she thought needed to happen first. Mary used a combination of 'dependency tools' to assess patient needs and discussion groups to surface anxieties and interpersonal difficulties within her team.

There were two issues that emerged from Mary's research activities. The first was about working closely with General Practitioners to provide respite beds to support the relatives of the elderly infirm, and the second was about coping with the conflict between two different cultures within the ward team. Mary brought a theme of patient centred care to our meetings and was able to explore the caring aspect of the dilemmas we presented. Teamwork and the primacy of caring and valuing each person were issues that Mary explored, and in so doing enriched the stories of others.

Stories in another voice

Before I turn to Jane's story and begin to draw together the issues and themes that emerged from the stories told, it is important to pay attention to the stories that were unspoken but 'heard in another 'voice'. These stories spoke of different issues but are equally important to include in the experiences of nurses.

There were two people in the group who chose not to take a central position and tell their own story. Each had a different reason for remaining silent and we as a group were aware of these reasons. Both Linda and Sara worked as a Clinical Practice Development Nurses (CPDN), and each had a different reason for needing space and time to think and consider, rather than tell about their work as nurses. At the time we were meeting together the role of the CPDN within the District was being questioned. In a climate of decreasing resources and greater demands for clinical services, any activity not directly contributing to clinical services was at risk.

Linda - 'finding a place to stand'

At the first meeting of the second research cycle, Linda stated clearly that she needed time to review her career and consider the opportunities for a changing her role. This she said would involve talking to people she worked with and thinking about where she wanted her career to go. During the time we spent together as a group, Linda explored her relationships with her work colleagues in terms of role development and new learning opportunities, and in terms of career change. Linda did this in her own work setting and brought very little of it to the group. However she contributed to the stories of others and added scenarios from her experiences as a nurse.

Towards the end of this second research cycle, I circulated a draft of my account of the fieldwork text gathered during the first research cycle and asked for feedback. Linda wrote me a letter containing feedback together with a personal story about her life as a child and young adolescent because this had been a part of her inward looking. As I read this letter I became aware of Linda's struggles as a young person and why it was so important for Linda to feel 'equal to' the colleagues she worked with. This quote from her letter illustrates something of her journey and why it is important to allow the 'silent voice' to speak in different ways.

> "These reflections really just underline for me how inextricable one's life and working experiences are/can be. So thank you for starting me on the reflection path and inviting

comments, though I am aware I have written more about personal issues than nursing. I hope some of it is helpful. "

At the end of our work together, Linda informed us that she has made a decision to pursue a multi-disciplinary masters degree in gerontology. She explained that she needed to test out her abilities against other professionals before making a decision about future directions.

Sara - 'life is for living and work is caring'

Sara chose to keep her own counsel for a different reason. Her choice was more about acceptance than testing possibilities. During the first research cycle Sara had played a significant role in the group, ensuring that issues were clarified and agreements were kept. At the first meeting of the second cycle she registered her intent to explore her work role with the view to a job change. During the time between the first and second session Sara was informed that the critical health problem she thought had been cured some years ago, had returned and required immediate treatment. This information was unexpected and serious, and it left her with important decisions to make about how she should manage her life from this point on. At the second meeting Sara made it clear she did not want to discuss her illness, but rather to "live life to the fullest" and to cope with any problems as they occurred.

"There are lots of things I want to do. I intend to fill my life with seeing and doing as much as I can. When I am no longer able, then I will consider what it means to me." We all respected Sara's right to remain silent about her personal life and to consider her work life in relationship to her personal needs to keep healthy. It was sometimes difficult not to inquire when it was obvious Sara was in pain. However, we respected her decision to put her energy into being fully alive and we limited our inquiry to her holidays and physical challenges such as running a marathon.

Sara, like Linda, contributed to others' stories, and informed us of how her life was developing in terms of changing jobs and learning new skills. Throughout our time together as a group, Sara always kept a focus on the centrality of caring in nursing, and often voiced how being a nurse meant giving care to others. This view often caused her to question her own value as a nurse, particularly as she became, and is, an active and full member of a teaching team. However her contributions to the development of nurses who provide hands on care to patients is very well received and appreciated. In this teaching situation Sara receives the kind of feedback that affirms her caring role and this seems to have resolved the issue that she presented in one of the meetings - "When is a nurse not a nurse?"

These two 'silent' members were very much present in the group and valued for their contributions to the stories that were told. We had glimpses of their lives as they were living them, and we heard of their experiences that shaped them as the people we knew.

Having provided a brief description of the stories told and not told, I now intend to focus on the central story and the patterns that emerged as we inquired and became involved in story telling.

Jane's story

The Historical Context

A year prior to Jane taking up a new position as combined Senior Nurse and Service Manager in a community hospital, both she and I had worked together on a 'Change Project' based in one of the wards in this same hospital. This project was related to a review of services undertaken in the hospital in the late 1980's. As a result of this, recommendations were made to change nursing practices from a task oriented approach to one that affirmed individualised patient care. It was this change process that Jane and I managed and in so doing identified organisational issues needing resolution. Not long after the project, Jane was appointed to the new position and was able to take some of the organisational issues forward.

Jane's emerging story

One area identified as needing improvement was the day care facility for elderly frail people. Day care facilities are very important part of the total care for the elderly, they often provide the choice between an elderly person needing a hospital bed and being able to stay in their own home. Therefore Jane's concern about establishing a responsive and appropriate day care service was accepted by all of us as important. Jane presented to us the difficulties she was having in encouraging staff to work together in a way that maximised the services to patients.

From Jane's account it seemed that professional roles were rigidly defined, with nurses 'looking after' the patients and other staff 'doing sessions'. This created inflexibility in the way staff worked and meant there were times when the services had to close, causing patients to return home early. This story is about Jane's attempts to create a sense of teamwork within the day patient services for elderly frail people, and the difficulties she encountered in doing this.

The telling of the story

Jane was given time to tell her story because it was causing her deep concern. It was also about issues we all agreed were difficult to confront and manage. Jane talked about patients being left for long periods of time with little to do, and at times services were cancelled because the day sister was away and other member of staff were unwilling manage in her absence. Complaints about inconsistencies and service closures were received from patients, general practitioners, and carers. Although at first it seemed that a lack of nursing staff was the problem, after assessing all the resources available and all the needs of the patients Jane realised this was not so. The problem from Jane's point of view was the inflexibility of staff, and the solution, as she defined it, lay in creating a team of people working flexibly together - convincing others of this was the challenge.

Jane recalled the processes she used to pay attention to her experiences as she interacted with others and reflected on her own thoughts and feelings. She explained how she focused on encouraging the 'day' sister to work flexible hours, and the physiotherapist to work with the nurses to manage small groups of patients. Jane also recruited and encouraged volunteers and carers to support the staff during meal times and to provide social activities for the patients. However, conflict arose when Jane tried to engage the occupational therapist as a 'team member' in the same way as she had engaged both the nurses and the physiotherapist.

Jane began the process of building this team by inviting the occupational therapist to work more closely with her nursing colleagues. This was unsuccessful and Sue, the occupational therapist, made her intentions very clear by stating that she had worked 'this way' (providing sessions) for fifteen years and did not see any need to change. This was a direct challenge to Jane who had expected some difficulties but not a direct refusal. This refusal was a set back and energised Jane to review her responsibilities and authority regarding other professions. It was clear that as manager for the Community Hospital she employed all the staff. However, the line of professional accountability for Sue was to the Head Occupational therapist in the Community and then the District Occupational Therapist.

After some discussion about the conflicting agendas, Jane came to the conclusion that much of what she was wanting Sue to do was not really professional duties but rather time management and rescheduling of work. Jane tried again to talk to Sue about rescheduling her lunch breaks in order to be with the patients whilst the day sister was at lunch, or working in the minor accidents clinic. Sue declined saying - "The patients do not need to stay all day, they never have in the past, so why should they now? Most of the patients can go home for lunch and the rest are quite happy staying on the wards."

Sue went on to say that it was the nurse's job to 'mind patients' and her job to work with people who needed help in living at home. These statements from Sue sounded very provocative to us, however Jane did not feel that this was the case at the time. She said that Sue did not appear to be defensive, the statements being said in a very matter of fact way which made it difficult for Jane to find a discussion point.

Jane told us that afterwards she felt angry, let down, and completely powerless to make any changes. As Jane talked the frustration fell away and the focus became her anxieties and worries about the care and treatment patients were receiving, and as we inquired further Jane began to clarify the dilemma that was 'driving' her tension and anxiety. This dilemma was about making choices between the needs of patients for 'good' care and treatment, and the needs of staff to feel valued and respected. Her concern seemed to be about making a choice that 'fitted' with her own understanding about the care that elderly people need to maintain some degree of independence.

Themes and Issues emerging

This expression of powerlessness, frustration, and concern, engaged members of the group in different ways. Some members provided a different perspective by suggesting possible outcomes while others shared similar experiences. Short scenarios mirroring Jane's situation were offered as a way of sharing experiences. A search for allies within the working context and for people with authority to draw on also centred our minds. These different perspectives affirmed several themes that were also contained in other's stories. These are:

- Working together as a team;
- Personal identity and role expectation;
- Caring for both staff and patients.

These themes held our attention as we shared our own experiences and suggested possibilities, no one person providing a definitive answer or solution. We all looked to Jane for cues about what might be possible and how we might support her as colleagues and fellow travellers. In trying to find ways through this complex situation Jane dwelt for some time on the dilemmas she felt trapped in and the decisions she felt powerless to make. This disclosure of personal thoughts and feelings created pathways for sharing our understandings about these dilemmas. Jane decided that she needed to take a stance that 'felt right' for her. The idea that she could treat Sue as she would a nurse who was refusing to acknowledge her responsibilities to others seemed a way through this dilemma. Jane was aware of the possible outcomes of continuing to press for change, however, when we inquired about this she explained the process she used to question her own integrity. This involved continually questioning her own intentions by asking - "Is this in the best interest of the patients?" - "Am I being unfair to staff?" - "Can I honestly do nothing?"

As this conflict developed Jane found herself unprepared for the long traumatic process that unfolded. In keeping to her initial purpose a disciplinary procedure became necessary and this ended with Sue agreeing to take early retirement. This process was not contained within the community hospital as the opinions and decisions of both the Head and District Occupational Therapists were sought to bring the conflict to an end. Both senior Occupational therapists supported and encouraged Jane in insisting that the changes she was proposing were both reasonable for Sue and advantageous to the patients.

However, their support was from a distance and Jane felt the weight of responsibility as the climate within the community hospital became very tense and fearful. People were not, nor could be, fully informed, therefore rumour was rife as people began to 'take sides'. Jane talked about how the personal nature of the discussions taking place made it difficult to be open with other staff. This non-disclosure encouraged suspiciousness and left Jane feeling misunderstood and at times doubtful of her own judgement. In telling of her dilemmas Jane provided a context for others to disclose their own experiences of conflict and confusion.

The life strategy of the story teller

Belenky et al's criteria for ways of knowing is used to inform these reflections.

Jane referred to the agenda she was given when she took up her position as nurse manager - 'to improve the viability of the hospital by managing the bed usage and increasing day patient numbers and patient satisfaction'. Jane felt confident in managing the nursing resources but unsure about other disciplines. She talked about her own ideas and in doing this gave a very clear picture of what she believed was the 'right' way of managing patient services. When difficulties arose Jane felt overwhelmed because she was unaware of what she had authority to do. To cope with this uncertainty she used people in authority to both clarify her position, and to be involved in the resultant actions. At the end of the ordeal some long serving staff, and voluntary organisers, made clear to Jane that they disapproved of the way she had treated Sue. Jane felt she had done the 'right' thing therefore coping with others disapproval was not a problem.

From my perspective Jane functioned mostly from the position of subjective knowing, she was clear about what she valued and what she wanted to see happen. She could tolerate disapproval and conflict although it caused her stress as she managed a rather long formal procedure. She admitted to feeling guilt about causing Sue's early retirement, however her belief that this was in the best interest of patients overcame any reneging on the decisions. There were times when Jane affirmed the need for people to work together, but she did not discuss this from another's point of view. Jane also used theories of change to inform some of her strategies but did not inquire into the appropriateness of the strategies she was using, nor did she test out the drivers for change she had identified. At the end she was glad it was over and turned to the next problem to be addressed.

A Sequel to Jane's Story.

Quite recently Jane and I discussed the difficulties she was having with the consultant with whom she needs to works closely *(Jane is now in a new job, developing 'nursing led' new acute day services as an alternative to accident and emergency).* We had a long discussion about working with doctors and I tried to explain the way I had managed to do this - by understanding where they are standing in terms of their life strategy. I gave Jane some ideas about opening this kind of discussion with a medical colleague, however her non-verbal messages said that this was not a familiar way of working. I then turned to 'Women's Way of Knowing' (Belenky et al, 1986) and gave Jane a copy of the article, suggesting that she read it and consider her own strategies for managing the differences in 'presentation of self to the world'. Jane rang me two weeks later and said. "I wish I had read that before I got into a fight with him, it is incredible the change, I now understand what makes him tick, it is really quite simple." *(I hope so!)*

My thoughts after talking to Jane were about how much one should interfere with the way people manage their lives and relationships, and I recall similar situations when I used the

ideas of Torbert with William the consultant I worked closely with. The question is - How much is helpful and how much is just about having a 'toolbox of tricks'? My strategy is to share what I know and what I have experienced and then to try and locate my understandings within the other person's experiences. To do this I explain as much as I can without being directive, and if I sense there is a flexibility of thinking I take the next step and provide written material. I then 'stand back' and leave people to create their own path - time is the reckoner.

Reflections, Interpretations and Explanations .

In making sense of this second research cycle I intend to explore my experiences of the story telling process, my use of ideas from the literature that informed some of our discussions, and my understanding of our preferred ways of working together. I will conclude with the graphic representation of the patterns that emerged from this story telling process. This 'Pattern of Story Telling" will have Jane's story central, with the voices of other story tellers which 'speak' to the issues contained within the themes that emerged, and linked by strands of interactions. My voice as researcher in the field is held partly within my autobiographical presence and partly in the ideas I brought to the groups.

Experiencing Story Telling

Jane's story provided a focus for exploring the issues we face regularly in our working lives as senior nurses, as did the stories of other participants. Thus, as we inquired of each other and shared our lives as nurses, so we created a pattern of linked experiences. For the most part these experiences were about the work we did and the relationships we developed within the work context. From my position as researcher with a research story to tell, there were times when it seemed appropriate to entertain another dimension, one that brought into focus the ideas of particular writers occupying my mind at that time. These concepts and ideas were a part of my inward-outward interaction and influenced the development of the research story and the pattern that emerged.

Giving an account of how these ideas were introduced, and sometimes explored, is not an easy task. I find it difficult to untangle the different threads of experience that were significant at this time. However there are tangible events that tie particular ideas and theories to this emerging pattern and that inform different parts of this research narrative. In order to create this sense of interconnectedness between theory and action, I will briefly identify some of these events.

Interweaving experiences and ideas

Meeting together, and entering into each person's life through the stories told, provided the impetus for exploring and writing Chapter 1 (Life Stories), Chapter 2 (The Experiences of Nurses), and the beginning text for Chapter 10 (Life strategies). It was at this time that I considered critically the writings of other nurses and found many of the traditional sources wanting with regarded to the interpersonal nature of nursing. In this context of story telling and

exploring our nursing lives, I discussed Newman's (1990) idea that 'praxis is research' and together we investigated how the nursing process, if seriously practised, involves a cycle of inquiry-action-inquiry. The aim of the nursing process is to increase the patient's awareness of their own potential and possible health choices, and if considered alongside Newman's sense of developing levels of consciousness, leads to a 'being with' stance.

This thread of experience is also woven into Binnie's (1992) presentation of the expert nurse as companion to the patient - walking alongside, noticing the way life strategies influence patterns of health and illness. Coaching, encouraging, and providing the care that cannot be provide by self or significant other, is the essence of this perspective and is central to Benner's (1989) research into the Primacy of Caring. These two perspectives became a part of my thinking, altering my seeing and doing, and as a consequence influenced the inquiry and the journey. We, as a group, entered into these ways of listening to and walking beside each other, sometimes challenging, but for the most part giving each other space to explore and direct our own journeys.

At the same time Torbert's (1981, 1991) ideas of interpersonal competence and transforming power became significant within my own work place, encouraging me to notice the way people managed particular aspects of their work. Once, I ventured to share with the group possible strategies that, from Torbert's point of view, are intended to encourage a mutual dialogue centred around inquiry. However, this produced a disjunction in the flow of conversation, much the same as Neil had produced in the first research cycle. This caused me consider - *"Why in this setting, where we are inquiring in a sensitive and insightful way has this intervention produced such a reaction?"* I now realise that chosen or preferred ways of being in the world (personal life strategies) are not always compatible with a planned, structured approach to negotiating a point of view or purpose. This sense of coherence between one's ideas of 'being in the world' and ways of 'taking action' became clearer as I paid attention to each person's life strategy and the way life stories 'speak to' this.

A Sense of Communion and a Sense of Self

The tenor of working together was one of communion - supporting, sharing, seeking understanding, and accepting difference. Agency as way of being needed to be incorporated into, rather than exchanged for, communion. Coherence between the way we thought about our actions in the world and the actions we took was a subtext rather than a clarity of purpose. It was Belenky et al's (1986) research into 'Women's Ways of Knowing' that provided me with a frame for understanding this coherence. The way each person approached the presenting challenges gave an insight into both 'ways of knowing' and 'preferred life strategies'.

My own sense making about my life strategies came from merging Torbert's ideas of how one becomes interpersonally competent with Belenky et al's ideas about the way women learn to use their minds. This sense of 'wholeness' gave me a more complete understanding of the possibilities available when one carries both consciously, noticing the genderedness of one's

strategies. Within this framework, 'agency and communion' (Marshall, 1984) became more relevant to my interactions in the workplace, particularly within the nurse-doctor relationship where power and powerlessness is ever present but not usually named as an issue.

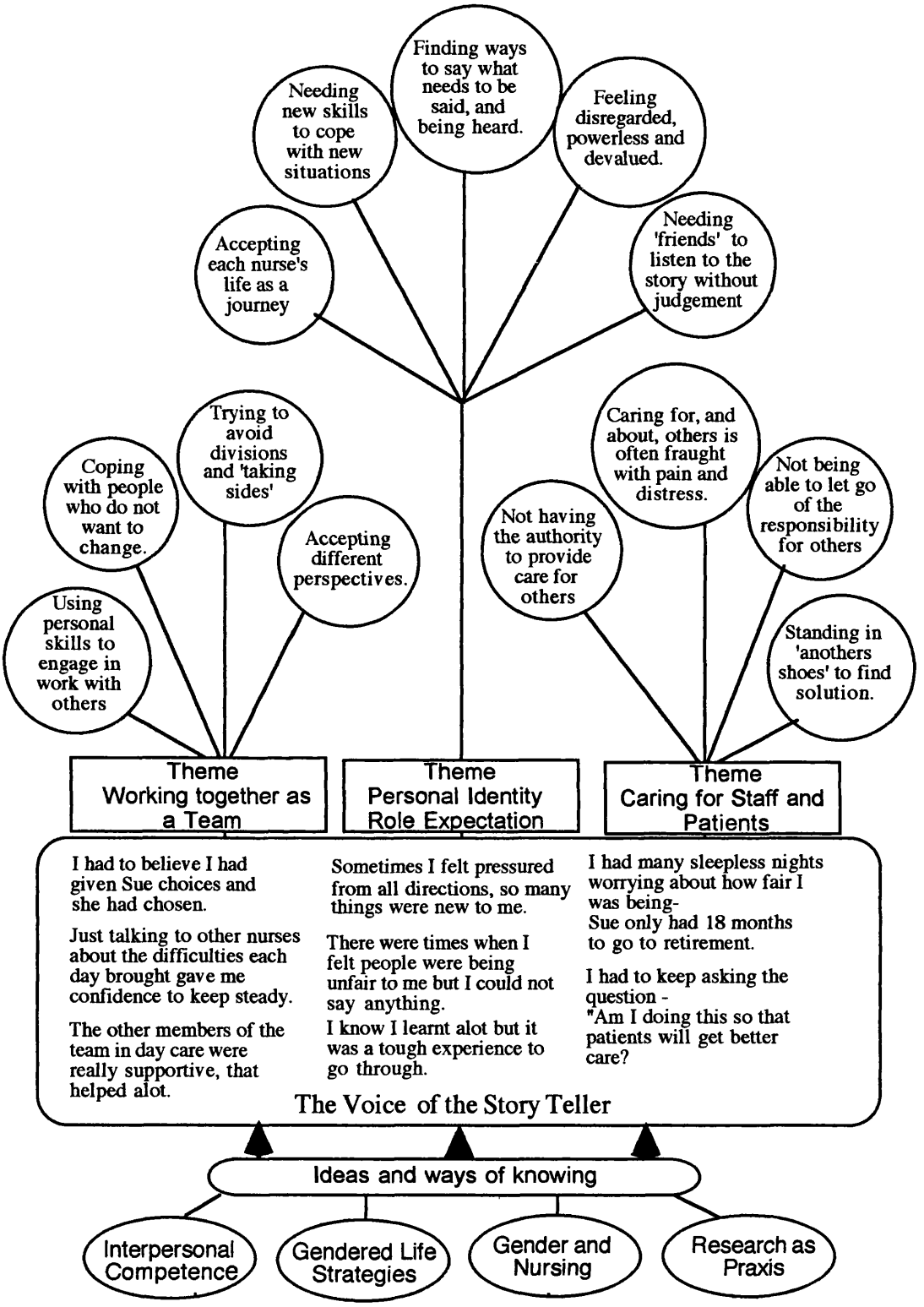
Considering my own Research in the Field

At this time I also re-searched the conflict that 'bubbled' through the first cycle of research. Listening once again to the audio tapes, and noting the dialogue that created either a sense of dissonance or clear conflict, gave me the focus I needed to pursue issues in nursing that are rarely 'named'. Once, during a group session in the second cycle, I ventured to share the different perspectives I had gained through this process. The response from the group was interesting, most people found what I had to say did not alter their original opinion of the particular situation. Two people inquired further and said they thought it was very possible that Neil was 'carrying' concerns that he had difficulty discussing in an open way. Another said that in his experience Neil tended to stretch an idea but it was always well intended. This experience further informed my ideas about our preferred ways of being in the world and helped me to clarify why I hold on to dissonance until I have time to seek out what I am only partially aware of. In chapter 12 I will explore this idea of what dissonance means to me by revisiting the episodes of 'conflict' in the first cycle of research. In doing this I will seek another perspective from which to make sense of my experiences.

Creating a pattern of merging ideas and interactions

Having presented my interpretations and sense making of this research cycle, it is now timely to consider the analogical representation of my experiences and understandings. This pattern represents the way we used stories to share personal experiences, and how, as we centred our attention on one person's story so that other's experiences were elicited, our understanding was enhanced. Thus, emerging themes are joined by threads of interaction where issues are affirmed through the voices of individuals. The ideas I contributed from the literature provided a buoyant and flexible base to draw and build upon.

Voices of Other Story Tellers



The Pattern of Story Telling

Conclusions

I have now reached the point where my understanding of this second research cycle has been thoroughly explored. I am not fully satisfied that I have provided the reader with a completely coherent account. However I have endeavoured to do justice to each person's contribution and to the ideas and understandings we shared together. From my perspective this section of the research journey has held the most surprises and has urged me to confront propositional, practical, presentational and experiential (intuitive) knowledge (Heron, 1992).

The next chapter will explore some of the personal experiences I researched as part of this second cycle. I will present these experiences as two separate stories and I will use the same framework for presenting and interpreting as I have in this chapter. I will also reflect back on each story and investigate how the telling of these stories exposes my own life strategies. This process will uncover the way I cope with conflict, manage relationships where power and gender hold influence, and make sense of my experiences within each given context.

Chapter Twelve

Introduction

During the second research cycle I chose to pay attention to several aspects of my work as a senior nurse. As it is impossible to give a full account of all the issues and challenges I pursued at that time, I have decided to present two very different experiences that illustrate particular aspect of the way I participate in my life as a nurse. Each experience affected me profoundly, touching both my sense of self and my need to understand the perspectives of others. Both experiences involved very personal interactions with others, either directly or from a reflective position, and both caused me to critically consider my own actions and reasoning. These two very personal experiences will be presented in story form beginning with a short statement about the context in which each story emerged, and my rationale for its inclusion here. I will then take each story separately and 'tell it' as I experienced it and made sense of it. I will then link each story, and the understandings I have now, to the pattern that unfolded in the second cycle of research. Finally I will consider how each story exposes something of my life strategy.

The emergence of a story

The first story is created from re-experiencing the field work data collected during the first cycle of research. In writing this story, I considered the original data together with the patterns and themes that emerged during the second cycle of research. This process of sifting and synthesising experiences and ideas has become the story. The second story originated during the second research cycle as I paid attention to my experiences at work. Like other stories that were a part of the peer group work, this second story tells of conflicting emotions and a sense of powerlessness as I face the power and control of others. Both stories are chosen now because they speak to the themes that emerged during the second research cycle and to my own personal life strategy.

Each story has something to say about teamwork, personal life strategies, and the nature of caring, however each story has something different to say about me. The experience of listening to the stories nurses tell, including myself, encouraged me to consider the interplay between the genderedness of nursing, the nature of power and the work relationships that nurses develop. Acknowledging this interplay has helped me to understand my own life strategy and the issues that create conflict in my life. This will become clearer to the reader as the stories are told in full and I make sense of my own experiences.

The first story

Understanding conflict as metaphor

This story began at the end of the first cycle of research, when I made a conscious decision to put aside the conflict that 'bubbled' through the first research cycle and concentrate on

developing the second group. Having put this experience aside but not submerged it, I was able to notice the way we managed episodes of conflict during the second research cycle and to ask myself, "Why the difference?' There were several possible answers to this question, however, the one that convinced me to revisit the field work data was that I had missed something important. The picture I had in my mind when I first recalled each episode of conflict was one of struggling to develop a climate of co-operation and support against a bombardment of doubt and mistrust. My reason gave me another sense, and my experiences in the second research cycle told me that my memories were coloured by my own anxieties. I therefore needed to go back and re-experience the conflicts, using a different lens and listening to a different tune. This story is about this revisiting and rewriting.

The historical context

The central character in this story is Neil, therefore I will begin with a brief outline of the relationship I had with Neil before starting the fieldwork. I first met Neil when he was appointed as team leader to the Post Graduate Service (PGS). This was a nursing education team and I was employed as a post graduate nurse teacher within this service. Not long after his appointment I met with him to discuss my plans to begin a PhD at Bath university. He informed me that he was also involved in the enrolment process at the same university, and would be attending an interview in the coming week. Later, when I inquired how he was progressing, he informed me that due to time constraints he had withdrawn his application. This seemed to be quite reasonable, and I thought no more about it as it did not affect my decision to pursue my own studies.

During the eighteen months I was a member of the PGS I developed and provided courses for registered nurses wishing to gain knowledge and skill in: assertion; working with people; managing change; leadership; and service development. In discussing with Neil my role within the team, he made clear that he was also interested in these areas of teaching. He stated that he was interested in the management of nurses and nursing, facilitating groups and organisational change. During this informal exchange, I became aware that if Neil was to pursue his interests, then my role would need to change. I decided to seek further clarity, and at the end of our discussion I suggested a team meeting to discuss future developments. At this meeting I inquired of Neil about his vision for the team and the areas that he thought important to develop. His response seemed to discount any planning together in favour of each person bringing ideas and proposals to him individually for discussion. Out of these discussions, plans could possibly develop.

It was clear to me at this meeting that I needed to think seriously about where I wanted to put my energy and direct my career path. I also felt the innovativeness of the team, where a 'can do' attitude was the norm and each person was encouraged to use and develop their skills and knowledge, was a strength that I did not want to lose. I realised if this changed, and I was

no longer able to function in this way, I would not want to remain with the team. Although nothing of real substance changed, an opportunity arose to join the Mental Health Unit as Assistant Director of Nursing and Service Manager, and I applied for the position and was successful. This was a newly created role which gave me the opportunity to further develop my skills in service development and change management.

A few months after I left the PGS, two of my colleagues also found new positions within nursing (I mention this because these two colleagues also joined my field work group). The PGS was a small team, therefore with three vacancies Neil was able to appoint new people to his team. I am sure this made it easier for him to develop the PGS in line with his own ideas and ways of working. This seemed to be a more liberating outcome than managing people who worked very independently and expanded their workloads with reference to their own networks and personal recognition.

I met Neil infrequently after I left the PGS, although I occasionally supported some of the PGS members by co-working with them on courses I had developed. I was surprised when Neil applied to take part in my research group, as I did not see him as a person who sought out peer group work. However, on receiving his request, I responded in the same way I had to other volunteers. I do not recall any anxieties or concerns about how we might relate to each other. By this time, given the informal information flow between nurses, I was aware of Neil's rather forthright way of working and his very individual approach to life. This did not pose a problem to me as I intended to encourage diversity within the group, and I assumed we (the group) would manage this. When conflict did emerge, I accepted it as a part of the group process, as one of the expected issues to be addressed in managing groups.

As I reflected and researched for this story, It seemed that much of what I had termed 'conflict' was a shared avoidance to enter into dialogue. This avoidance was in the context of the challenge expressed and the behaviour accompanying the challenge. As I attended to these challenges I recognised familiar concerns about nursing in code, or metaphor. This story is about surfacing these metaphors, and the dilemmas that lie hidden within them.

As I searched the audio tapes and found the dialogue that highlighted each episode of conflict, I was at once struck by the way Neil delivered his challenges. They often cut across the dialogue that was occurring, and they always held a tone of 'personal truth' that did not invite discussion. However, in listening carefully to what was said and recalling my own feelings at the time, a different meaning emerged. This discovery cut across my remembered experience with a sense of amusement and fascination. It is this discovery that I will attempt to illustrate. To do this I will tell of four situations where the challenge caused a break in the conversation, and where this led to diversion or silence. These challenges questioned: the nature of nursing; the ability of nurses to work together; the primacy of caring; and the uncertainty of role and personal identity. These themes will provide the frame for exploring this

'second level' of experience, and the sense I now make of it. I will also include my own question of authenticity, and validity, because I am now aware this was what I was searching for as I revisited the field work data. I will then conclude by considering how the telling of this story exposes my life strategies.

The nature and meaning of nursing

Neil's first challenge came when we were discussing how we would pay attention to our practice as nurses to inform what we did as nurses. As we began to get agreement about keeping an 'open mind' when researching our own actions at work, so Neil cut across the dialogue with a very strong statement. He said that it was not important to focus on nursing, it was not an issue worth considering. Researching nursing, he said, was a waste of time because all we really had in common was working in organisations. At the time this challenge seemed out of context, because it questioned the very reason we were meeting together, and made no sense to me. It also cut across the dialogue and created a 'thick' silence, begging a question that no one risked asking, including me. I felt trapped and unable to find words to speak. Images of others I have known who project such attitude were all I had, and that felt dangerous.

When revisiting the audio tapes I was aware of two competing understandings. One was the resistance to being deviated from our intentions to explore our lives as nurses, the other was the sense that there was a message, a conundrum, that I needed to unravel. Now I can verbalise what I was struggling with, I can name it as uncertainty and the fear of losing a sense of self. In this journey back into the silence I was able to hear a voice cautioning too much disclosure. I was also able to hear the voices of other nurses saying "What is that I do that is uniquely nursing?" "How can I tell other colleagues about what I do and expect them to regard me as an equal?" What I now hear in the challenge is a word of caution about being too ready to stand out and be noticed. Fading into the complexity of the organisation, presenting research that seeks to identify and measure tasks, is much safer and less anxiety provoking than exposing ourselves to public scrutiny.

Hearing again the silence in response to the challenge also questioned my way of being in the world. I became at one and the same time both vulnerable and offended - vulnerable because I did not have the language to respond effectively, and offended because the statement devalued the role nurses play in safeguarding, nurturing, and encouraging others to care for themselves. Now I have a better understanding of the kind of silencing that silences my sense of knowing about myself, and my identity as a nurse. I have learnt to take the stress and pain that comes with being vulnerable. To do otherwise offends my own integrity, when silence is to concur

(Speaking out and learning to cope with being vulnerable is a risk I take, to do otherwise means loss of integrity. This is central to the second story.)

The Importance of Working Together

The next challenge that I have selected from within this story addresses how nurses work together. This challenge came as we were considering what it meant to be open, honest and 'with' each other. The value of self disclosure and positive feed back was being explored when Neil made another of his 'truth speaking' statements. This time his interjection insisted that it is impossible to create groups where honesty and openness is accepted as the norm. This, he explained, was because nurses are unable to cope with conflict, avoiding saying anything just to keep the peace. This challenge caused a silence that was broken by one member suggesting that we should be able to keep quiet if we wanted to. This released the tension and allowed tentative agreements to be made, however the episode left me with feelings of doubt and uncertainty, at the time.

Revisiting this episode highlighted the tensions and potential risk in encouraging nurses to be outspoken and confident, when the work climate often encourages division and suppression. I am now fully aware that developing a research methodology that relies on people being open and honest with each other is fraught with difficulties. The metaphor for me is about wanting to retain an ideal view of what nurses do, and being fearful of exposing the real difficulties when we try to enact this.

In another context, Neil questioned whether nurses are able to work together to achieve common goals without very clear instructions. This questioning seemed very dismissive of the interpersonal skills that nurses do have and their ability to manage their own work in a creative way. However, having revisiting this interchange, I now see the issue of nurses working together in groups, and teams, as very difficult to achieve. Not necessarily because they do not have the skills, but because the context in which nursing is practised limits the possibilities. My experience of the second research cycle necessitated a very different approach. It is clear that there was a message in Neil's challenge whether consciously given or not. Time to reflect and affirm one's own perspective in an open and honest way with ones peers is not easy to achieve. My sense making of this difficulty lies in the genderedness of nursing, and this gives meaning to the silences and lack of clarity.

The Primacy of Caring

The caring relationship that develops between nurses and patients is an accepted part of nursing, and is often the focus of discussions about what nurses do. My view of nursing in the past held the nurse-patient relationship as central and other relationships as peripheral. I have now come to acknowledge that I and my peers place caring central to our relationships with colleagues and peers, as well as patients and their families. This awareness of the need we have to develop a context where caring is given and received with dignity, was challenged by Neil as we sought to agree group norms and acknowledge the tensions between a our professional and personal lives.

The first challenge was about developing a climate of trust where honest interactions, risk taking, self reflection were encouraged and supported. Neil doubted that nurses were capable of creating this relationship with each other because. He argued, "They don't want to spend time unravelling where people are coming from." This point of view received no verbal response, and at the time I was aware of the tension rising as this negative statement cut across what was, I thought, a genuine attempt to agree some basic rules about how we intended to work together. Now I make a different sense, one that brings to the surface the difficulties in building relationships in the work setting because of the way we work and because of the nature of our work. Most nurses work over a 24 hour period, and this mitigates against spending time together on a regular basis to building good relationships. The time we do have together is usually devoted to sharing information about the needs of others.

The extra energy and time needed to develop supportive and inquiring ways of working together, given the context in which most nurses work, is a problem we did not want to confront. At that time I wanted to put my energy into developing a cohesive group, where confronting these issues might be possible. Neil's confrontation was out of time with my understanding of the way groups develop an ability to address these conflicting situations. Respecting different points of view, allowing issues to emerge from our work experiences, and keeping the tension at a workable level, were more important to me at this stage. This agenda prevented me from being open and honest and thereby confronting the issue to reach another level of understanding. The irony of this situation does not escape me, and I know it is repeated in other areas where conflict is left unresolved. Somehow, caring for, about, and with people requires choice or an avoidance. This sometimes leaves a sense of loss, or the guilt of neglect.

The second challenge was a criticism from Neil to people arriving late for the meeting, and it highlighted the tension between our personal and professional lives. We were all aware that being late for meetings was usually about not being able to release ourselves from a commitment to the needs of others. Therefore no one directly responded to these criticisms, maybe this was because we had already agreed it was better to come late than not at all. I think this was my rationale. At the time I felt the criticism as an irritation, now I realise it brought to the surface the choices nurses make between duty to the patient, carers, and other colleagues, and the commitment to meeting with peers. In previous discussions we had agreed that meeting together was personally satisfying as well as professionally supportive. Sacrificing personal needs in order to meet the needs of others was an aspect of nursing present in many contexts. However, when Neil complained about attendance and lateness, no one responded with agreement, provided an excuse, or a counter argument. Silence was the response. I now realise the obvious answer was not spoken, leaving me with the question, "What is the message that is present but not received?"

Behind this direct attack on his own colleagues, I heard anger and a sense of exasperation about the nature of nursing and perhaps the way we are so easily led by others to meet their needs rather than our own personal commitments. I now see a link between this criticism and the very nature of nursing - that is, to be available and responsive to society, the organisation, doctors, other professions, and patients 24 hours a day. Seeing the world of nursing from this point of view means that taking time to develop peer relationships in anything more than a one-to-one way is destined to have a low priority. My agenda was to search for another answer, where paying attention to the difficulties and impossibilities was held in abeyance. How else could I have kept my own enthusiasm and energy level high enough to see the journey through?

Personal identity and role expectation

As we began to discuss our roles as nurses, we touched lightly on role expectation and role conflict. This opened up the possibilities and choices available to us. Neil challenged this idea of choices, declaring quite strongly that nurses do not want to be confused by choice. Nurses, he asserted, needed clear goals to be set so that ambiguity and 'failure' is avoided. This very forceful and 'truth speaking' presentation was followed by an uneasy silence, broken by a personal statement by one of the group members, and a change of focus in the conversation. At the time I thought this remark was very simplistic, and not necessarily how nurses see or want their roles to be. However, it was not so much the words that focus my mind, because clarity and purpose had been addressed earlier, rather it was the way the words were spoken. The tone of voice and the no nonsense approach brought back memories of being overpowered by someone else's truth and feeling insignificant. Neil's interaction brought together the gender opposites for me, and I felt overpowered by the 'truth' and unable to anchor the possible.

I realise now that my way of leading the group was about working from a feminine perspective, allowing differences to emerge and ideas to flow. I was not ready to create the structures Neil was requesting. I was aware of the disharmony and confrontation that his remarks elicited. I did not hear the 'message of distress' until I connected this bid for certainty with the 'swamping' that is present in the work setting. In this setting, nurses experience their roles as becoming more complex and ill defined as old structures are remove, creating a climate of uncertainty and constant change. This sense of being overwhelmed by change and uncertainty is clearly present at all levels of nursing. The stories that were told in the second research cycle speak to this.

This perceived threat, when boundaries are loose and the limits to ones role unclear, echoed in Neil's monologue about Einstein and the law of relativity. Here there was tension and a hint of distress, as the future was pictured as less and less certain because "a+b does not necessarily lead to c." At the time it seemed to me to be completely irrelevant to our

discussions, and duly received a silence. I considered this silence to be about the inappropriateness of presenting an abstract theory in the midst of discussing personal experiences. However, at a second 'hearing' I interpreted another message, one that spoke about a yearning to return to the days when nursing was task oriented, and predictable.

This call for predictability spoke to the pressure that nurses feel when they take on more and more work without any certainty about where and when it will end. Neil's point was not just about being clear about one's own work, it was also about having a sense of responsibility for the job satisfaction of junior staff. When I consider this issue from my position, it seems that the likelihood of tangible results, and clear beginnings and endings, reduces as one becomes more experienced as a nurse. The issue of not being in control of ones work life, but relying on the co-operation of others, is a real one that does not end with nurses working together. The central story in the second cycle of research speaks to this uncertainty.

Personal validity and authenticity

Reviewing the data developed during the first research cycle allowed me to pay attention to, and interpret, the potentially unspoken messages contained within each episode of conflict. This allowed me to consider the issues of personal validity and authenticity. The process of finding new meanings where conflict appeared to be unresolved has brought into focus my own sense of what is valid and authentic. Before bringing this story to an end, I will intentionally consider validity and authenticity as I relate the final episode of unresolved conflict. The conflict arose when we were discussing our intentions to research our own way of functioning in both formal and informal groups. As we considered possibilities and tested ideas, Neil cut across the discussion by declaring that, "Just about all relationships in organisations are artificial, because no one has any say about who they work with and therefore they are contrived and false." He also stated that as the "people who are thrust upon you" are not interested in working in a team, it is pointless to try and develop team work. In these statements there was a sense of outrage at being put in an impossible position, and frustration at not being able to achieve a satisfactory result.

Although the first response from the group was silence, there was a tentative probe about the universality of his statements. In reconsidering this seeming impasse, I contemplated what this 'no choice' situation meant for nursing. This faced me with a real dilemma about the validity of working in groups and the need for nurses to act authentically when giving nursing care. The lack of choice identified by Neil can have a serious effect on the ability of each nurse to perform well, particularly in situations where nurses rely on each other to manage the unexpected. If one has no choice, then there is a sense of vulnerability about who is reliable. I this is so, then it is important to work hard to achieve 'a good team' in the workplace and to encourage all nurses to learn the skills to work co-operatively with others.

The life strategy of the story teller

The question here is, "What does my account of revisiting these episodes of perceived conflict tell of my life strategy?" My answer to that is simple. I have noticed the issues and themes that speak to the way I live my life, and seek to interact within different contexts. A more complex answer tells of a pattern emerging as I bring into focus dilemmas important to me. This happens as I listen to my own inner voices and allow my emotions to colour the scene. My ability to 'put aside' one understanding in favour of another comes into play when a wider agenda or 'good' is apparent. There are many examples of this in the above story and throughout the thesis - the transition from the first research cycle to the second is one example. Here I put aside the conflict and focused on ending the first group and beginning the second. Managing endings and beginnings in a way that liberates me, and others, from the past, and allows the future to begin hopefully, illustrates a central theme of my life strategy. This theme has been a part of my life since my first husband died.

Accepting that people hold different truths can sometimes make my life chaotic as I try to acknowledge different ways of making sense. My writing sometimes echoes this. Holding on to alternative views, and my own life principles, means that at any time a past experience may surface and add weight to the present. This makes my understandings rather complex and may, or may not, be apparent to the reader. It certainly has been apparent to me as the narrator of my life experiences.

Throughout this research text, and particularly in the above story, I recognise some basic principles that guide my thinking and acting. For instance, there are times when it seems that people are intentionally being difficult and uncooperative. However, I hold the belief that each person does the best they can, given the resources available to them and the experiences they have had. This principle allowed me to revisit the conflict in the first research cycle and pay attention to other possibilities, hence another story takes form.

As I write I have struggled to present information in a clear and concise way, although I know that life is not like that. My mind is messy, and people are a mass of contradictions. What I have noticed, and what sense I have made of this noticing, tells of my life strategy. This second story is set within a clinical department in a Mental Health Service where I was the Assistant Director of Nursing and Service Manager. It is about doctor-nurse relationships and tells of experiences that stirred up conflicting emotions and a sense of powerlessness within me. It also tells of the struggles that occur as different motives and intentions are pitted against each other. This story also speaks to the ongoing challenge of developing communities of inquiry in a competitive and uncertain world.

The second story

Merging cultures or gender struggles?

In the first account of the second research cycle I introduced my work context and the way I approached my research intentions. In doing this, I described the key dimensions of my relationship with William the Clinical Director, and considered my strategies in developing this relationship. I will now present an episode within this relationship to illustrate the way different life strategies can become entwined with unforeseen results. I could tell a story where this merging of different ways of being in the world created something we both valued. However I have chosen to present a story that exposes my vulnerability and the unpredictable nature of relationships, where the dimensions of power are in some ways related to gendered roles. This story speaks to the themes that emerged from the second research cycle and to my own vulnerability when I chose to confront the power of doctors. The particular episode occurred during a departmental marketing meeting, therefore, I will 'frame' this story within the marketing agenda. I will also consider how my life strategy is 'written' as I tell the story and I will conclude with William's comments about my account.

The historical context

When this particular episode occurred I had been working with William for two years, during which time we had learned to work together, rely on each other, and plan and complete several projects. We did not achieve this on our own. The staff in the department, although often seeking different outcomes, worked together to improve both the services and the physical conditions. The changes within the NHS had placed this small department in a vulnerable position, and in order to survive we needed to have contracts outside our own health district. For this reason, I had secured a 'pot of money' to explore our position within the market and the possibilities for developing existing and new contracts. The ultimate aim was to develop marketing strategy that secured our existing contracts and identified the priorities for development.

The emerging story

Prior to the meeting in which this episode occurred, a small team of senior staff, including myself and two marketing consultants, had researched several possibilities for marketing. The agreed intent of the marketing meeting was to discuss this information in order to set priorities for developing the marketing strategy. As one might expect, people tended to research areas of interest and/or competence. Each one of us used our networks and past experiences to formulate possible marketing options, consequently what we brought to the meeting spoke to different agendas. It is important to provide a brief outline of these agendas before presenting the episode because this is where the conflict emerged.

Staff involved in this marketing process were:-

- The two consultants - William, who worked with all addictions except 'hard drugs', and Andrew , who mostly worked with 'hard drug' users.
- The consultant psychologist - David, who worked across all areas of addictions and focused on cases that were complex and difficult to resolve.
- Four nursing staff - Colin, who was involved in health promotion and harm reduction projects and worked closely with Andrew; Peter, who worked almost entirely with people with alcohol problem and was particularly interested in education; Susan, who managed the inpatient services; and Steven, who worked with addictions teams in outlying districts.

In considering the way forward and the possibilities for marketing, Andrew took an entrepreneurial approach, having decided that working with drug addicts was very demanding and that he now needed 'another string to his bow'. He decided to search out the possibility of running a private convalescent service for people who had completed their surgical or medical treatment and need some psychological interventions to change their life styles. William decided to find out from general practitioners the effects of fund holding, and whether direct contracts with them was a possibility.

David and the two of the nurses pursued the gaps in treatment and care, identified as being rehabilitation and case management. Steven visited all the adjacent Health Districts to inquire about possible needs, and David pursued other external clinicians who had spoken of particular gaps in services. Susan and I looked at possible accommodation for extended service resources by acquiring a small farmhouse in the grounds of the hospital, and Colin and Peter consider the educational needs of other health workers and the general public. The two marketing consultants interviewed our existing purchasers and potential purchasers who at that time were sending us the occasional patient.

The marketing meeting

We began the meeting with one of the marketing consultants outlining the procedure for clarifying, assessing, and prioritising all the marketing options. This took some time and I could see Andrew getting restless and occasionally questioning the methodology. At a point where an explanation had just been given to Andrew, William took the lead and stated that the purpose of the day was to make sure we all understood each option so that the rating was valid and we could get on with planning. Andrew then stated that he did not see why we needed to bother with all the options because we only needed to consider new services. I was immediately aware that if this proposal was accepted then the options of securing and developing existing contracts would not be considered. As we had already lost one contract it seemed an unreasonable suggestion to me. I thought about what might happen if Andrew continue to pursue this line of action and decided to challenge him.

I explained why it was important to developed our existing services, in order to secure resources for exploring new markets. Andrew responded by saying that we already managed the existing markets, therefore the exercise should focus only on new ideas. I tried again to explain why improving and extending existing markets to new customers was important and likely to bring timely results. As I spoke I also realised that to focus on 'new' options was to disregard the work of most people in the room. This I considered would be counter-productive. Andrew then replied that he could not see why I wanted to waste time on things that could be done outside the meeting. I replied that valuing everyone's contributions meant hearing their ideas and opinions in light of the options they had pursued. I then went one step further and commented that to say each person's information is not worth considering in this meeting is to devalue their efforts. Andrew then accused me of "wilfully misinterpreting" what he was saying.

This remark hit me quite suddenly, and I realised I had expected Andrew to be provocative but I had not expected him to personalise the argument. I replied that it was not my intention to be provocative, and I finished by saying that I believed we were placing different values on what was important. As I sat back to catch my breath, William stated that he agreed with Andrew, that we should limit the options to those we really needed to consider now. Silence was the answer from everyone in the room, including the marketing consultants, the four nurses, David and myself.

Eventually David broke the silence and said that he thought we had been invited by the consultants to consider all the options, and as we had agreed that we needed a shared understanding, we ought to get on with it. William then came in sharply and declared, "We have not been invited to do anything, we are in charge, and we will do what we want." At this point the whole scene crystallised for me and I was aware of William and Andrew 'standing tall' at one end of the room, the marketing consultants retreating to the back wall, and the rest of us sitting in a small semicircle not looking anywhere. I began to feel swamped by conflicting sensations, and unsure about whether I was going to be able to maintain a detachment from the feelings that were welling up.

I took out my pen and notepad and began to write, initially to compose myself. As I wrote, so my feelings and anxieties came alive on the page. This activity allowed me to detach myself from the one-sided conversation going on between very uneasy management consultants and very determined doctors. It was some time before anyone else spoke.

Eventually, William commented on the process, saying that it (the process) was not working and we had better stop because people were obviously unhappy with the situation. David then joined with William, saying that he had been feeling uneasy for some time. David then proposed that we try and be more inquiring, so that others were able to contribute. This remark from David jolted me back into the room and raised my anxiety. I did not think that I would be able to say anything if I was asked for an opinion. Andrew said something to me and

before I could gather my thoughts together, Colin leaned forward in front of me and said to Andrew:

> "You are railroading people, you always do this when you want your own way, and you do not want to hear from anyone else."

Andrew retorted with a rationalisation about people needing to take risks. Colin responded with :

> "You are doing it again, you have been doing it a lot lately. You have a lot of good ideas, and I value most of them, but you do not listen to other people. You either ignore them completely, or discount what they have to say. You do this to me often."

At this point Andrew leaned forward in his chair and challenged Colin to, "Get it all out!" if he was feeling resentful. Colin replied that he had said all he wanted to say.

I realised that Colin had protected me form Andrew's possible attack and I felt relieved. When David requested that every one should have a chance to comment on the process before we decided to continue I was able to formulate my opinion. William agreed and Andrew grudgingly concurred. Steven said he did not want to talk about resentment or differences and so remained silent. Peter said he was happy to continue and agreed with what had been said - he did not identify which ideas he agreed with and no one asked.

I said I thought we should work through the options as quickly as possible and took up Andrew's suggestion that we set up meetings to consider some of the existing marketing options after this meeting. The two marketing consultants agreed with this and I could see they were relieved that the process was 'on track' again. At this point William went to the flip chart and took charge of the process. I began to relax and we completed the activity without any further discord. The two marketing consultants remained peripheral to the exercise but agreed to work with some of us outside the meeting and to assist us in exploring the priorities we had identified.

Before I conclude this meeting and tell how William and I resolved this very difficult situation, I will present an account of my own reflections written at the time. My intention in doing this is to expose how I experienced this clash of interests, and how all the tensions and difficulties in nurse-doctor relationships descended and rendered the most experienced of us mute. In this internal dialogue I surface the key aspects of my own life strategy that seemed, at that moment in time, to be contested.

How can they (Andrew and William) be so oblivious to the non-verbal feedback. We call this a marketing team and it is like being in school. This process is not valuing the activities of people who support and cope with the everyday work - I feel devalued and not affirmed for all the energy I have put in to keeping the tasks on course, and in trying to make things happen. I feel

rejected and injured. I would like to say - "If this is who you are, and what you want, then I will find another way of working that does not involve putting myself at risk."

I feel too vulnerable to speak, I hear the voices speaking but it makes little sense. No one really exist except the medics and the marketing consultants, everyone else has faded into a mist. There is no energy to make decisions, I can understand why. Do they (Andrew and William) understand why no one is answering their questions? It seems so obvious that this kind of approach does not help people to work together. We are now going toward complete separation and I am not going to help resolve it, they will lose the energy of everyone else except the marketing consultants.

Perhaps this episode is telling me something I need to hear. Maybe this is an important learning point in that I now know how easily I can feel vulnerable and alienated. Confronting Andrew was not a well considered act, and yet if I had not, I would not feel any better. This is so familiar, I am wanting to work co-operatively so that everyone can own the results, and the medics are into the 'mystery-mastery' game of competition and power-over.

What will I do if David inquires of me? I cannot risk speaking my mind again, What will I do? Suppress my concerns? Explain? Or divert away? Why have I been so affected by William aligning with Andrew? Am I angry with the two marketing consultants for not managing the process better, and with William for trampling on people in order to please Andrew. Why am I thinking this? I have encouraged William to join with Andrew in public and in our meetings, and now I am offended by it.

If I am honest I know that this is OK, so why am I finding it hard to break from this emotional heaviness. I would like to comment on this process but I cannot. David has done a good job of holding it, perhaps I can support him, at least that is safe. Maybe there is a message in this experience. Something about trying to 'stop the tide' or holding on to too many loose ends.

I then turned and made a comment to David and this released me from my 'stuck-ness'.

The Meeting ended with every one agreeing their tasks and arranging a follow-up meeting. I felt absolutely drained and just sat still collecting my thoughts, deciding what I could possibly say to William to release the tension. He pre-empted anything I had thought of saying by coming across the room and sitting beside me. He touched my hand and said,

"Can I tell you a joke?"

My inner self shrank, a joke felt like the last thing I wanted to hear from him. I think I smiled in recognition, and then I said, "Not really, but I will listen if you want to tell me."

He replied, "Do you know the difference between a sausage and a dog?"

"No." I said.

And he replied, "A sausage feeds the hand that bites it, and a dog bites the hand that feeds it."

I replied, "Thank you but it does not help at the moment."

And he returned, "We need to talk about this meeting."

And I replied, "Yes, but not now."

We talked briefly later that afternoon about doctors not feeling at ease about business management, and needing to be in control of situations. We moved quickly into discussing more objective issues about developing the marketing strategy and coping with competing demands. We agreed to continue improving our position and relationship with our existing purchaser and the wider organisation. William also agreed that he would work with Andrew on the idea of a new convalescent service and leave the rest of us to develop business plans for the other options. Having agreed this I did not wish to take the conversation any further. I needed time to think about the day. I said I was feeling very exhausted and needed time to think, then I offered to write my thoughts on paper and give them to him the next day. This I did.

Reflections and interpretations

The process of getting everyone to the meeting was rather difficult because everyone seemed to have competing demands. We eventually began late with a presentation of the day by the two marketing consultants. This lowered the energy and possibly the alertness and made me aware that getting team participation would not be easy. When the conflict arose I struggled with my own need to protect myself and the need find a way of valuing the work each person had brought to the meeting. I tried to be honest and open and I trusted that this would not be rejected, but it was. The aggression from Andrew did not silence me at the time. I was able to express the perspective I had on the way personal values and life strategies are present in our work situations - I proposed that our different value bases promoted different priorities. However his accusative stance with me did silence the other nurses and David. William joining with Andrew silenced me.

This silence continued for a considerable time, and I became very concerned about what this meant for others in the room. I cared about the nurses being silenced because open inquiry is not possible in situations where the power of one silences another. I also cared about the impression William was giving to the marketing consultants, and to the nurses, by taking an offensive stance. I realised that although I had worked with William to address the suspicion between the nurses and doctors, what was happening seemed to be driving us backwards.

I also struggled with my feelings of hurt and anger as I realised my own integrity was being questioned by Andrew , and I began to doubt my own strategies. This doubting rendered me powerless to speak. I wrestled with my understanding of the needs of others in the room, and

the longer view of why we were meeting. I realised that if the situation had just been nurses and doctors, we, the nurses, might easily have remained silent and made our own decision after the meeting. This is what often happens as doctors assume that their opinions are accepted by nurses, and nurses feel unable to present their own point of view. Anger, tears, resistance and 'forgetting' what was 'agreed' are some of the ways nurses cope with this situation. In the end I did none of these, but held my 'fragile self' steady until I was able to contribute in a competent way.

Now , as I reflect on the process with all my experiences of working with doctors available to me, I realise that the risk I took was ill considered and placed William in a 'no win' situation. The aggressive response from Andrew called on William to intervene and he did so in favour of Andrew. Had he done otherwise I would have unwittingly split the two doctors and this would have created more serious problems when it came to making departmental decisions. Although I could not have known this would happen, when I reflect on the incident I realise the chances were high - both William and Andrew were standing firmly in their 'doctor shoes'.

To expect William to support me, or even comment on the process, was unrealistic and would have put at risk all the work we had achieved in delineating responsibilities between doctors and nurses. I acted without considering the possible outcomes. Perhaps I felt too safe and unaware of the possibilities, or perhaps I was mesmerised by the long introduction to the day and needed some action. What ever it was, I had played a part in it, and now I needed to find a way of healing the rift without losing any one, including Andrew. Time, and the tenacity of people to maintain relationships, helped me to return to a place of calm. Balancing relationships, caring for the wider group, and managing the conflict between personal identity and the expectation of others, will always be a challenge for me.

Since writing this story I asked William to read my account of the incident and tell me if he felt I was misrepresenting him in any way. He agreed to do this and we met to discuss his response to my request. At this meeting I made short notes, and after he had left I re-created the following dialogue. Our conversation began with me asking William if there was anything in the text that he did not want to be included in my research text.

He replied "I don't need to add or take anything away, it is how I remember it except you have been very generous, thank you for that."

"Can we talk a little? Because when I told you I was going to write about that particular episode, you did not seem to remember it clearly."

"I did not remember the joke I told you. I remembered when I read it, I think you were very generous about it all."

"It is the truth as I see it."

"Yes I know, I recognise the way it happens and I know it will happen again. It happens all the time. I can see people being hurt and upset, but it is always too late. All I can do is spend time mopping up afterwards."

"That's true, you do that. My concern is about how it affects what happens or does not happen."

"I know it is not a good way to get co-operation, but there is no where for me to go."

"What does that mean William?"

"I am a doctor, that is the only place I have to stand. If I had somewhere else to stand I would."

"Are you talking about your role as Clinical Director and the lack of clarity?"

"Yes, if I had a proper contract that said clearly what I am responsible for and what authority I have to make decisions and get things done, then I think it would be easier to stand alone."

"Not alone, surely, William?"

"No, not necessarily alone. If I had another option I would take it."

So we talked again about what the possibilities were for changing his situation, and out of this discussion we considered the future. At the end of the conversation I made mention again of my account of the way our relationship developed, and he said:

"You were always very fair about what you did, you have presented it very briefly and that is easy for me." At this point we began to talk of other things and the episode was not mentioned again. On reflection I realise we adopted a familiar way of interacting, where we moved easily into discussing personal experiences. There did not seem to be any threat, and yet in a different context I would have moved warily. This I still find disturbing.

The life strategy of the story teller

In this story I focused on my relationship with William because it highlights my life strategy, and in doing so exposes the interactions between agency and communion. William entered our relationship with a 'mystery-mastery' life strategy well rehearsed. He did not disclose his feelings knowingly and worked hard to maximise winning and minimise losing, focusing on objective evidence rather than subjective knowing to achieve this. In Torbert's terms, he moved between diplomat and technician - diplomat when he sought support and assistance from the professor at the nearby university, and technician when working as a clinician. I, on the other hand, came to the relationship understanding the 'mystery-mastery' life strategy but preferring to take a constructivist point of view to understand and work with others. My intention was to achieve real change in the department, and to do this I knew I would need to adjust my purposes, strategies, and actions to accommodate William's ways of working. The

outcome was more than I had anticipated. As we focused on tangible targets that brought added value to the department, and consequently to both of us, we were able to modify our preferred ways of being and to learn to take risks.

During the three years we worked together, I worked hard to keep our relationship open, supportive, and constructive. Coping with the stress and discomfort when timing and strategy were paramount to success, was a challenge that came early in our relationship. It is important to pause a little here and consider how I learnt to work effectively with William, and how I brought new Ideas and ways of 'getting the job done' to the department. For me, ways of knowing in the world are about dialogue with people, ideas, and one's own inner world. The ways I have acquired knowledge has been influenced by the experiences I have had and the person I was and have become. Therefore, in considering the ways I sought knowledge and understanding and learned to participate within this work context, I will speak from my personal experiences and from the way I understand Belenky et al 's (1986) epistemology of gaining knowledge. I will begin by considering the particular stance I took to work with William, then relate the way I acquired understanding and knowledge within this context. To do this I will refer to the writings of Belenky et al.

Ways of Knowing and the World of Work

In pursuing 'common ground' with William ,I observed myself working predominantly from a 'connected knowing' stance. However, there were times when I challenged William's ideas and actions. In doing this I took a more separate knowing stance, participating in a debate about ideas, theories and methodologies. Consequently, when I attended to how I gained knowledge and understanding, I came to see my changing patterns of interaction as a reflection of my accommodation to others. Having now investigated this movement between understanding the other through empathy, and making decisions through debating idea, I have a different view. Gaining knowledge and feeling confident to act in the world independently is not an 'either/or' situation. I have learned to reach out to others in order to understanding their thinking, and I have learned to pursue and debate ideas in order to increase my own knowledge. However, each is also linked to the way I interact with and experience the world.

It is through understanding the way others think and act that leads to collaboration and the achievement of mutual goals. Debating abstract concepts and models of working can lead to increased opportunities, innovations, and personal satisfaction. However, for me each is not mutually exclusive because it is the interaction of ideas, whether interpersonal or intrapersonal, that excites my mind, increases my energy, and holds my attention. This leads me to consider two issues. The first is whether I can rightly label myself a connected knower or a separate knower (I will revisit this in the next chapter). The second is whether my chosen ways of gaining knowledge 'speak' to my life strategy. In contemplating this second point, I considered

the epistemology or 'ways of knowing' created by Belenky et al, and found that, from my perspective, the way one gains knowledge cannot be separated from the process of knowing. Thus my experiences lead me to believe that the context one finds oneself in will influence the way one learns and adapts in order to achieve one's purposes. The person one is, and becomes, will also reflect one's chosen ways of seeking, acquiring and confirming knowledge.

The scenario I painted in the marketing meeting portrayed aspects of my life strategy and something of my knowledge-seeking in action. I am aware that I hold back in presenting the knowledge I have gained from more abstract processes until I sense the other person will treat this knowledge with respect. In the marketing meeting I confronted a situation where the issues and procedures we had agreed were being 'hijacked'. In doing this I moved away from joining and understanding, to presenting the rationale we had all agreed previously. I did this from an informed position. I learned from this situation that although I invited debate and discussion, I received a 'power over' stance from Andrew, and a wall of collusion from both Andrew and William. This confirmed for me that if a person is only able to make sense from one perspective then possibilities are limited. I needed to think carefully about the sense I made of this confrontation before I made any decision. This, from my point of view, is because interactions occur within a given context and the strategies to cope will, of necessity, reflect this.

I chose to record and present this scenario because it discloses the tensions and conflict that arise when differing world views and agendas are forced together within a particular context. These differences reflect gender, the ownership and use of power, and the way we as people make sense of ourselves and the world. It is a very small snapshot of my experiences of working with William, rarely did we become 'at odds' in public. This was one such occasion, but I cannot recall another of this magnitude, Privately I could speak my mind to William and listen to his point of view., and he, I believe, reciprocated. Developing this reciprocal and respectful relationship was the first challenge I tackled. Seeking to understand how William made sense of and acted in the world was as important to me as creating a context for respectful and open relationships. Listening, inquiring and paying attention to possibilities was a part of my strategy as I worked with William, and it flowed over and between myself and other colleagues as we developed strategies together and supported each other. My disappointment, anger, frustration and silence in the marketing meeting, was in response to the carelessness shown towards the efforts and achievements of others in the room.

So what did I learn from this relationship?

I suspect I learned all the things one learns when the barriers are down and we let the other person see our vulnerabilities. I also learned that there are people within people, and that they emerge in different contexts. Just as my different ways of being and acting emerged as we worked together, so did William's. Thus at times our roles as doctor and nurse were

submerged, and we worked together as friends and colleagues. This confirmed for me that any relationship where there is a willingness to 'really know 'the other has great possibilities. I think this is why I have a passion to liberate nurses from being subordinate to doctors, and so liberate doctors from needing 'hand maidens'. In developing my relationship with William, I sought to create a context where mutual respect and an understanding of each others point of view allowed differences to be resolved. This was my intention, and although the stress and challenge was quite considerable, we both experienced satisfaction when quite extraordinary goals were achieved. I once asked William, at a time when we were being open with each other about our life strategies, why I allowed myself to be vulnerable. He replied - "Because that is the way you are, you would not be you if you were not sometimes vulnerable." .

Conclusion

This story highlights some of the important issues I confront as a nurse and illustrates some of the themes and issues I shared with my nursing colleagues. We all sought to create a sense of identity as nurses, and doing this confronted power and conflicting role expectations. My confrontation with Andrew was about my desire to affirm team work and allow the silent voices to be heard. In doing this I was silenced. My concern to safeguard the integrity of others, as well as myself, is about the nature of caring and reflects the way women tend to view moral issues from a responsible and caring position (Belenky et al, 1986, p.8). This seems to be a part of my life strategy, therefore to conclude this chapter I will turn back to "Women's ways of knowing" and the experiences of other women as they seek to cope with the experiences of life and 'hold' their voices.

> "Even with women who feel they have found their voice, problems with voice abound. Some women told us, in anger and frustration, how frequently they felt unheard and unheeded - both at home and at work. In our society, which values the words of male authority, constructivist women are no more immune to the experience of feeling silenced than any other group of women." (Belenky et al, 1986, p.146)

and

> "Social expectations, which shape the behaviour between the sexes, continues to exert pressure on constructivist women to accept the status quo. Although persistent in their efforts to be heard and to hold on to their new sense of voice, constructivist women can end up accommodating the needs and ground rules of men out of the sad wisdom that change does not come easily." (p.148)

I no longer work for the department, however, I still have a working relationship with the management team there. The services the department provides have increased to include a service for 'complex cases' and people needing short term rehabilitation. The convalescent service never eventuated and the department is still struggling to clarify it's contracts with the

main purchaser. However, the staff have diversified and now work flexibly across the different client groups. Their ability to seize opportunities when they arise seems hopeful, and at the present moment, exciting.

Chapter Thirteen

Introduction.

In this final chapter I intend to review the research journey in terms of what I brought to it, how it unfolded, and what I now take from it. I will identify the three different pathways that 'carried' the research journey and comment on the way each took precedence at different points in the journey. I will begin at the point where I entered the research journey and with the question I held at that time. This will set the scene for introducing the three paths of Constraining, Constructing and Connecting. Each of these paths will be described separately, then I will briefly tell the research story as a complete cycle of research (Rowan, 1981). This is the best representation I can make, in summary form, of how I have conceptualised rigour and quality of knowing throughout the research.

Unfolding and Merging Pathways

Taking the first steps

I entered this research journey with the following question in mind:

> "Can a group of experienced nurses meet together, share experiences, and inquire into each other's nursing practice in a way that enhances their work as nurses and creates personal and professional knowledge."

This question arose as I thought about the clinical, management, and teaching roles that contribute to my understanding of nursing. However, my experience of managing groups and my commitment to experiential learning was the trigger for researching within a group context. Consequently, inviting other senior nurses to participate with me was a natural progression and was more about my life strategy than being purely a reflection of nursing. I therefore began the research journey with some clarity about what I wanted to research, and how I wanted to develop the process. Finding an appropriate methodology was the first challenge I set myself. This search involved conversations, debates and key presentations, shared with my research colleagues at Bath University, and with my nursing colleagues in discussions about the relationship between practice and research.

I decided that a qualitative research methodology, compatible with the way nurses tend to work together and able to be applied within a group context, would suit my purposes. Discussions with my nursing colleagues helped me to identify different aspects of my research intentions and my own strengths and weaknesses. Consequently, the three pathways of Constraining, Constructing and Connecting, presented their 'way signs' very early in the research journey. Constraining placed pressure on me to 'fine tune' the way I worked with others to meet the requirements of a research methodology. Constructing challenged me to apply different ways of thinking about research questions. And Connecting alerted me to my own ways of working and the strengths I have developed through working with others. As I reflect on this

development I am aware that although these pathways became apparent simultaneously, the Constraining pathway gained precedence early in the research and influenced the way I set up the field work. Consequently this pathway is presented first.

The Constraining pathway

When I speak of Constraining, I refer to a way of being and acting governed by a perception of externally derived conditions or standards. Paradoxically, this also enables these experiences to be pursued and understood in ways that are unfamiliar, and therefore have the potential to liberate. Research methodologies are constraining because they require a degree of attention and analysis not usually required in everyday communications with others. As I began to probe relevant methodologies and frameworks, I discovered several qualitative researchers whose ideas, methods and research tools seemed appropriate to my research intentions. After carefully considering each possibility I decided that:

- Co-operative Inquiry supported my intentions to research within a group context and it explicitly defined the validity criteria for this activity. Its minimal requirements described by Reason (1988) as being: "--the nature of the involvement of all participants should be openly negotiated, each should contribute to the creative thinking that is part of the research, and relationships should aim to be collaborative." (p.9)
- Collaborative Inquiry seemed to have a personal 'fit' with the way I viewed reflection in action and interacting with others in an authentic and timely way. Torbert (1981) describes the heart of Collaborative Inquiry as: "What practitioners really require is a kind of knowledge that they can apply to their own behaviour in the midst of ongoing events in order to inquire more effectively about their common purposes, about how to produce outcomes congruent with such purposes, and about how to respond justly to interruptions." (p.140)
- Naturalistic Inquiry presented me with the idea that reality is co-created through interactions with others within a particular context. This felt compatible with my own understanding of the different meanings each person may take from any one situation and at the same time share some common understandings. A way of inquiring into nursing through different lenses was provided by the three philosophical questions: 'What is there to know?' (ontological); 'How do we know?' (epistemological); and 'How do we go about finding out?' (methodological).
- Although I used Heron's (1981) Co-operative Inquiry methodology as a framework for the two cycles of research, his experiential research model seemed at that time to require a sophisticated level of self awareness in order to consciously move between thinking, feeling and acting. Therefore, I decided to develop a research process for planning and managing the research project using the cycle of research developed by Rowan (1981). I made this decision because I considered the way nurses manage the

nursing care cycle follows a similar process. This matching of experience with the research process would, I believed, assist in the development of a 'researcher role' by each participant.

Several methodologies were compatible with the way I intended to engage in the research. However, I decided to use a Co-operative Inquiry methodology because it favoured a group context for research, and seemed to provide both techniques and methods compatible with the way nurses work. It also made explicit the validity criteria for judging the quality of the knowledge produced. Rowan's cycle of research provided me with a clear frame for managing the research process. I intended to introduce Torbert's ideas of reflection in and for action when it seemed timely and appropriate to do so. I also consciously affirmed the idea that 'reality' is co-created through interaction with each other within a given set of contexts, and that individuals make their own sense of this shared experience.

Once I was clear that Co-operative Inquiry was an appropriate research method, I made every effort to establish a context that encouraged valid and appropriate data to emerge, and I rigorously complied with my understanding of the methodology and the validity criteria. By the time the first group session was agreed, I had a clear map of how I intended to manage the group and research processes. My personal role was clearly to facilitate, participate, and manage the research data.

As the first cycle of research progressed I became pre-occupied with managing the data, and communicating with group members between sessions - all other considerations faded. The validity criteria occupied much of my planning, participating, and reflecting time as I guided the group through each of the research stages, providing tapes and summaries of each session. The conflict that bubbled throughout the first research cycle erupted during the final stage, creating tension and discord. This awkward situation required that I reflect in the midst of action and respond coherently, and this catapulted me into a different stance.

My sense of integrity did not allow me to treat this conflict in an arbitrary way. I therefore considered several ways of making sense of and managing the situation that developed. However, my attention remained centred on completing this first research cycle and on keeping the ownership of the conflict firmly within the group. Resolving the situation involved a process of inquiry and opinion seeking and this, I believe, initiated a change in the way we worked together. At the time I was pre-occupied with concluding one research cycle and agreeing the next, therefore I relied on both intuitive and objective procedures to resolve the issue in a temporary way. I am now able to bring into perspective the importance of this episode. I now realise it was at this point the research path began to turn towards constructing meaning and connecting experiences.

In the first research cycle we created a group where trust and honesty was encouraged and supported, thus providing a context for sharing our experiences of nursing. In agreeing to

participate in a second group we openly negotiated our individual research intentions and re-affirmed Co-operative Inquiry as the methodology of choice. However, I now recognise that Co-operative Inquiry as a methodology for managing cycles of action and reflection, from planning and reflecting within the group setting to implementation and data collection in the practice setting, did not happen in its full form. What we took forward was an agreement to rigorously research our own practice, and this transpired to become cycles of reflection and action occurring in the workplace. What we brought to the group instead were our representations of these experiences, for support, discussion and inquiry, and this became a collaborative process.

Thus a way of working emerged that affirmed and supported reflection and action within the world of practice.

> "The model of collaborative inquiry begins from the assumption that research and action, although analytically distinguishable, are inextricably intertwined in practice." (Torbert, 1981, p.145)

It is now clear to me that we each pursued our own research within the work setting using the skills of Torbert's Action science. We then brought stories of this to the group and developed a support and inquiry group to encourage effective interactions within the workplace. Through the telling of stories we each described our use of reflections in-and-for action to meet our affirmed intentions. However, we did not 'name' this change in the way we managed the research process, and I struggled to make sense and validate these experiences. Intuitively I knew we were being attentive, inquiring, and consistent within the group. As people told their stories, the quality of their reflections, their self inquiry, and ability to 'behave' differently to achieve their research intentions, seemed to demonstrate rigor. I know that my research within the workplace involved 'reflecting in the midst of action' and behaving in ways that were sometimes unfamiliar. I was able to give a full account of my own experiences but I could not 'set them against' the validity criteria that is contained within the Co-operative Inquiry methodology. Nor could we validate each other's experiences in this way. I felt caught in a frame that did not make sense of the data we had produced. I was unable to see a way through this dilemma because I had set myself the task of being more rigorous, and therefore, to deviate from the defined cycles of reflection and action contained within the Co-operative Inquiry, as I understood it, was to render the research invalid.

My self analysis tells me that I had become so committed to rigorously researching within a Co-operative Inquiry mode, I was unable to acknowledge that we had adopted Torbert's Action Inquiry approach at the beginning of the second research cycle when we agreed to use reflection in-and-for action. The process that developed from this decision allowed each person to develop their own cycles of action and reflection, but more importantly to fine tune an awareness in action. It was listening to members of the group describing the decisions

they made to take action within a live interaction that held my attention and posed a problem when I came to write the research account. In retrospect, it appears possible that Torbert's ideas had the most effect on how we worked together, and yet I could not directly introduce any of his strategies within the group. The language seemed to create discord rather than connection. However, during the process of group inquiry I contributed in ways that affirmed particular strategies attributed to Torbert. In this way Torbert's ideas became currency - or so it seemed. Concerns about interpersonal competence and congruity between purposes, strategies, and actions, were some of the issues that arose from the stories of others and invited experimentation with new behaviours. However, at that time I carried a nagging doubt about the validity of the methods we were using, and a concern about making 'research' sense of it all.

This anxiety came to a head when I came to analyse and make sense of the data, and again this crisis of confidence catapulted me, with the help of my supervisors, into another frame. The question of my warrant for using stories as a way of representing experience created a space for story telling to become a method for understanding and making sense of the work we did together. Ironically, despite all my anxieties about rigour, precision, and validity, when I let go of the 'must do', the relevance, applicability and richness of our work together became clear. This enabled me to validate our research activities and through this new lens, we became a supportive, inquiring, and challenging group of colleagues.

This constraining pathway was the most difficult and challenging for me and caused me to reflect frequently on the openness I encourage as I work with others. Holding firmly to a particular frame is important, however, my awareness of other possibilities and perspectives is always hovering around me. The next pathway of 'Constructing' brings into focus some of the issues that caused me to confront my own ways of knowing, and in doing so, to gather all the constructions I made as I journeyed through this research.

The Constructing Pathway

I came to this research with ways of knowing that enable me to work creatively with others. Rarely do I feel trapped in any situation. 'Thinking about how I think' was not one of my preoccupations. Consequently, this Constructing pathway elucidated my awareness of myself as a 'thinker', and provided a connection between the work of Pfeiffer and Jones (1973 - 1990) (that has informed my thinking about learning over the years) and my understanding of constructed knowing. This connection is important to my understanding of myself as a thinker, therefore it is worth explaining briefly.

In experiential learning, participants are involved in planned exercises that challenge familiar patterns of acting, thinking and doing. After completion of an exercise each participant shares their own sense making of their experience, and relates this experience to some aspect of their lives. This sharing of experience, individual sense making, and personal discovery,

encourages each person to construct their own understanding and to test it out. I now realise I choose this way of working because it 'fits' with my thinking about the world, myself, and the people I work with.

Although experiential exercises were not used in the research group, I brought with me this way of viewing and sharing both experiences and ideas. Being able to share experiences and develop some common understanding of what this might mean does not deny that each person will construct their own sense of it.

The group started with the questions:

- What is there to be known about nursing?
- How do we know about nursing and being a nurse?
- How do we find out about what we do that is nursing?

These illustrated the complexity of co-creating a reality about our experiences as nurses, and at the same time acknowledging that each of us will make sense of our experiences from our own perspectives. Personal experiences will always hold very personal meanings for each individual, although each may have participated in the 'same' experience.

The aspects of nursing I chose to explore sometimes held similar interactions and activities as those which others in the group reported on, and we sometimes co-created a reality about these experiences. However, the sense I made of my experiences are my own and did not necessarily echo the sense making of others (There is a comment at the end of this chapter from one of my nursing colleagues about my sense making of a shared experience). This need to co-create a sense of what it means to be a nurse is an ache that I experience and sometimes share with others and the nurse writers I chose to engage with 'speak' to this aspect of myself.

The particular nurse theorists I chose to inquire of were in contrast to the work I had completed in my first degree in nursing studies. In these studies nursing theory was about taking ideas and concepts from the physical and social sciences to create a knowledge base for nurses. For me this did not 'speak' fully to my experience of being a nurse. Physical, psychological, and social sciences surround and penetrate the understanding nurses have about the health-illness continuum , and are important, valid, and necessary for nurses to practice effectively. However this does not inform what I understand to be the essence of nursing.

In selecting particular nurse theorists to inform this research journey, I searched the literature for writers who explored the world of nursing through the personal experiences of nurses. This led me to select several writers who highlighted important aspects of nursing, and in doing this, illuminated some of the ways I have come to understand nursing. In summary:

Binnie (1992) portrayed the skilled companion and facilitator of other's learning.

Benner (1984) contrasted the meaning making of novice and expert in a shared context.

Newman (1990) explored her own journey from science to 'patterns of life experience'.

Benner (1989) viewed skilled and compassionate care as a necessary balance to individualism and competitiveness.

Gordon (1991) confronted the genderedness of nursing and the importance of valuing the caring role.

These are some of the ways of understanding nursing that support my exploration of being a nurse, and informed my involvement with others in gathering knowledge about nursing.

The connection between ways of knowing, gender and nursing, is a question I carried for many years. This Constructing pathway encouraged me to explore my own constructs and those of others. "Woman's Ways of Knowing" (Belenky et al, 1986) was instrumental in opening my eyes to the way I experience my own knowing, and led me to pay attention to the way others explicitly, and implicitly, communicate theirs. This search for understanding was an important part of my journey through the second research cycle. I gained insights into myself, my nursing peers, and the colleagues I worked with.

Torbert's (1981) work on developing interpersonal competence also played a part in this search for understanding. I found that Torbert 'spoke' to the agentic (Marshall, 1984) and Belenky et al (1986) to the communal in me. I now see both Torbert and Belenky et al as searching for connected and communal ways of knowing. My experience tells me that there is a need to temper connectedness with some agency and separateness if a sense of harmony with others' life strategies is to be achieved.

This Constructing pathway uncovered my life strategies and enabled me to explore the lives of others through the stories they told. I became more aware of myself and others through these stories and the connections we made with our professional work and chosen ways of working. Exploring my own life strategy and reflecting with others has enabled me to pay attention to the ways I explore ideas, gain knowledge and choose to act in the world. I am aware my preferred stance is to connect with the ideas of others by attempting to enter their world and understand the meaning they make of their experience. However I am also aware that I have a clear understanding of 'the place I stand' and the principles that guide my actions in the world. It is, therefore, through integrating intuitive knowledge with ideas gained both directly and indirectly from others that I am able to speak with my own voice. Constructing and reconstructing ideas and understandings has been an important part of this research journey.

The Connecting Pathway

As I entered the research journey and began thinking about the research questions, this Connecting pathway appeared as a wide misty territory containing images, voices and feelings. As I gradually gained a sense of direction I became aware of three different aspects of my life - woman, nurse, and a creative leader of others. The source of this Connecting pathway is

rooted in this triad. To begin building a personal sense of self, I pursued several aspects of my personal and professional life. This included:

- exploring parts of my life through writing autobiographical stories;
- visiting groups of nursing colleagues and exploring issues facing nursing;
- discussing the genderedness of nursing with a nursing colleague who was completing a PhD about the historical development of nursing and changing roles of women (now completed - Rafferty,1992)
- devising a research proposal and presenting it to the nursing ethics committee;
- beginning an inward journey and paying attention to how I performed my role as a nurse leader, and a manager;
- beginning a literature search of expert nursing practice, with the focus on 'self' as an instrument of caring and function of nursing groups.

During the first research cycle I was pre-occupied with bringing together the ideas about nursing generated within the group, and locating both themes and issues within this information. However, throughout this cycle I held two agendas:

- valuing each person as an individual with their own unique life experiences;
- using critical incidents in our nursing lives to investigate the nature of nursing.

Exploring my life experiences led me to present highlights from my personal and professional past. This was received with enthusiasm and others chose to share something of themselves as the first cycle progressed and we considered our personal and professional lives. This process connected our lives as people with our lives as nurses, and brought to the surface issues of power, gender, authority, responsibility and the relationship between doctors and nurses. Many of these issues were not directly identified, it was more about joining together over a particular incident that highlighted power and powerlessness, or gender and responsibility.

On reflection, I realise that my main objective was to create a context where each was able to participate by presenting their own experiences. Connecting through our lives as nurses was uppermost in my mind at that time. In the second cycle of research I was thoroughly immersed in exploring my own role and life strategy. Within the group I was able to give my undivided attention to who ever needed to 'take centre stage'. This process both informed my own research and encouraged me to share some of my insights. I consciously put aside doubts about whether we were complying with the agreed methodology. The way we inquired, shared personal experiences, and actively listened to each other was too valuable to doubt. I had never experienced a nursing work group with this capacity to disclose personal experiences and draw on the experiences of others to solve both personal and professional issues.

The need to ensure that the connection between us held securely became very important to me then, and informed my own life strategy. Exploring differing life strategies provided the connection between this pathway and the other two. Weaving these pathways together through the use of story built a picture of our work together. It was through this process that the issues and themes became clear and informed our individual experiences of nursing. Before I conclude this review, I intend to give a short resume of the research journey as a complete research cycle using Rowan's (1981) research stages as a framework for my own and others experiences. This will expose the temporal nature of this journey and lead into the sense I now make of it.

Creating a sense of completeness

Being - finding a place to begin

I began this research journey with some clarity about the research purpose. However, I took some time moving between different aspects of my life, just 'being' before I began the fieldwork. I reflected upon what I was bringing into the research and considered the possible ways of researching that might be compatible with my understanding about nursing. I consulted colleagues, fellow students, family, and other nurses. This provided me with a sense of what might be possible. Agreeing the research boundaries involved finding an appropriate methodology that met the purposes I had developed. Once this was achieved, I applied for formal permission to research nursing within the health setting. This approval punctuated a formal beginning and opened the way for setting up the research project. Recruiting experienced nurses to this research project was the first step, and set the scene for beginning the first research cycle. At this point the 'being' stage was completed and I was ready to think about 'doing' research.

Thinking- what can be known about nursing?

This first cycle was wholly taken up with exploring what we understood about nursing and what we thought 'being' a nurse might mean. Our group time was taken up with discussing a wide range of experiences that seemed to relate to our roles as nurses. We also considered our personal lives and how much these influenced the way we practised nursing. Ideas came and went, issues being important at one point and not so at another. By the time we reached the end of the first group we were clear about some of the themes and issues that held significance in our working lives.

It was at this point our focus altered and we moved away from this continuous search for 'what nursing is', and began to take charge of our own individual research intentions. This activity involved a firm commitment to purposefully engage in research within the context of our lives as nurses, and to consciously use the research tools of reflection in-action and for-action to inform these experiences. We also agreed to share our experiences in a collaborative way, preparing the way for encountering the world of work.

Encounter our lives as nurses

This stage of the research cycle found each of us working as participants and researchers within our own work settings. The data we gathered from these experiences became the central focus within the group context, and story telling the method we used for sharing these experiences. Each member of the group contributed experiences that told of our lives as nurses. We created an agreement about what each of us intended to do and how we might support and inquire of each other. However, each made our own individual sense of it. By entering into each other's experience we created patterns that highlighted themes and identified common issues. I also began to pay attention to the writings of other nurses and at times I shared ideas within the group. This was a time for constructing knowledge out of experience and sharing these insights with each other. The nature and essence of nursing became an important theme for me at this time. My exploration of gender and life strategies provided a deeper sense of the genderedness of nursing. I became aware that I favour a connected way of knowing and this provided an insight into the way I develop my relationships with colleagues.

During this stage of the research journey I experienced the weaving of the Constructing and Connecting pathways as confusion. I now realise that Torbert, Belenky et al, Marshall, and the nurse theorists were all inviting me to view the research process through a different lens. I needed time to detach myself from the constraints I began with. Once I did, the lens became clear and I was able to affirm my own experiences.

Sense making - patterns possibilities and challenges

As I wrote my own stories and made sense of this second research cycle, I experienced an ease of moving between each pathway. Creating the pattern that emerged during the second cycle enabled me to extract the repeating themes, and come to understand the different ways of knowing and the gendered approaches I use in work situations. Thus life strategies, ways of knowing, and discovering the nature and essence of nursing seemed to flow as the paths merged and created a sense of wholeness. It is timely now to make sense of this complete research journey.

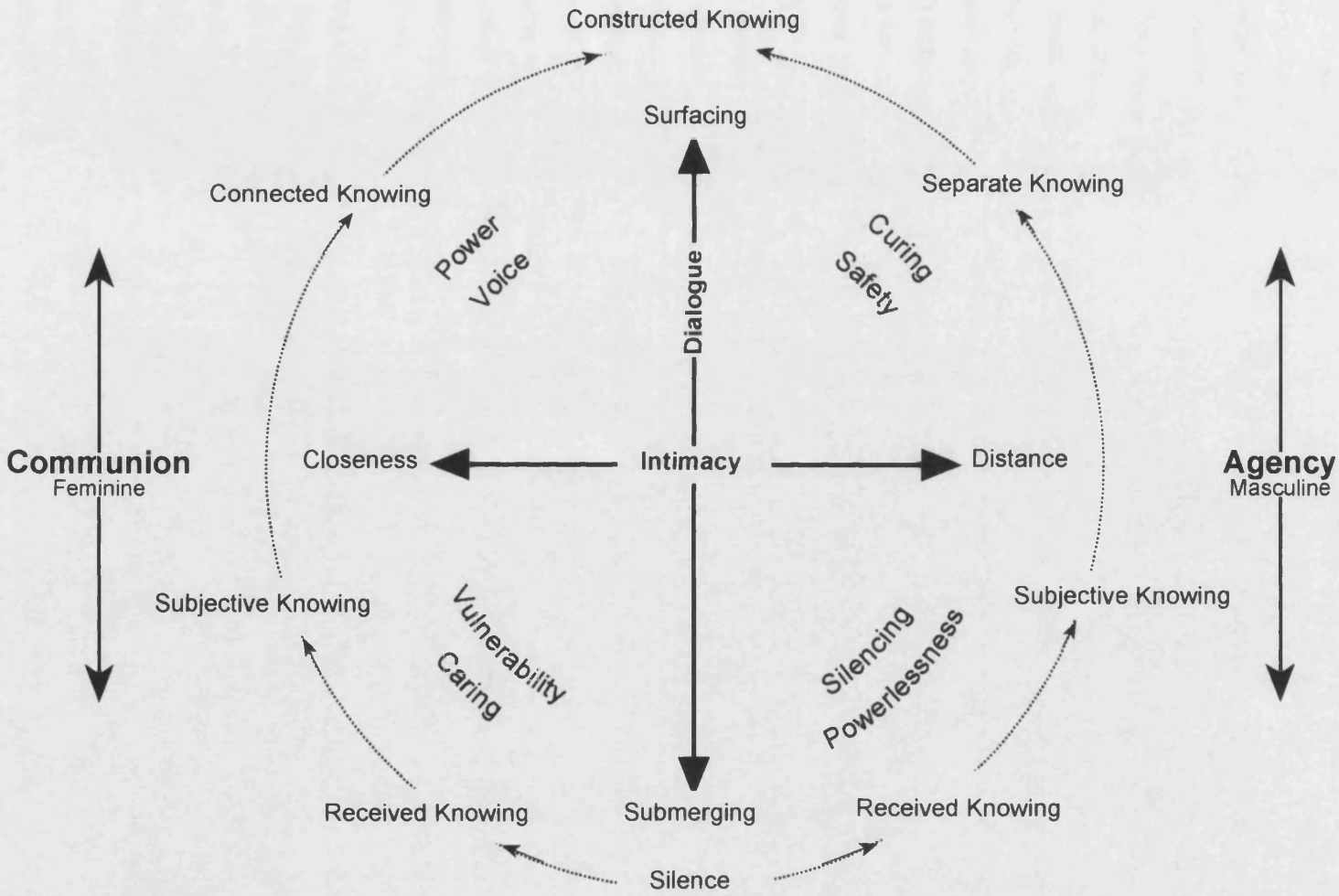
As I think about this final stage, I am aware of 'arriving' at a place where the essence of nursing is intertwined with gender, power, ways of knowing, and ways of being. This speaks to me of centredness, movement, polarities, perspectives and changing relationships. In this last section I will endeavour to explain how I came to this position and the meaning I now take from it. I will begin by revisiting the themes and issues I took from my own experiences. I will then create a schema incorporating my understanding of the 'dialectics of nursing', the genderedness of life strategies, and 'Women's ways of knowing'. My comments and ideas about future possibilities will flow from this schema and reflect the themes that emerged as we shared our experiences of nursing.

The themes and issues that speak to me as a nurse.

When I reflect back on the way themes emerged and issues gained focus early in the research journey, it is clear to me that we 'spilled out' our experiences in a way that made it difficult to identify issues of importance. When we began to search our experiences together, and I intensified my own inner search, this randomness became centred and tangible. Listening more carefully to my own voice and paying careful attention to the voices of others enabled me to hear, observe, and feel the struggle to surface ideas and personal experiences. I heard myself speaking of surfacing in situations when others spoke of submerging thoughts and feelings to avoid pain, rejection or self criticism. Thus surfacing and submerging created a dialectic, with dialogue as the transaction between these two polar opposites. Thus interpersonal competence and the way each of us made sense of the world and our place in it became a theme I pursued.

Choosing to research my personal experience of the doctor-nurse relationship speaks to the value I place on developing effective and mutually satisfying interpersonal relationships. I risked acknowledging and expressing, to myself and others, my own developing relationships with William. Here, changing and shifting degrees of intimacy was my experience - at times closeness, at times distance. From my perspective, these polar opposites of surfacing-submerging and closeness-distance are made viable through dialogue and intimacy, and are central to my emerging understandings of being a nurse and affirming other nurses. Although these two dialectics form the central framework in my mind, I have discovered that others are held within this frame and relate to ways of knowing and being in the world.

To provide a clearer picture of this developing schema, I will begin by explaining more fully the central dialectics that provide the framework. I will then invite the reader to engage with me in exploring the spaces between each polar point. When this is completed I will explore the connections between this schema of 'The Dialectics of Nursing' and 'Women's Ways of Knowing' (Belenky et al, 1986), and gendered life strategies (Marshall, 1984). This exploration of connections will add two more dimensions to the schema - a 'gendered' dimension and a 'ways of knowing' dimension. Gender is about agency and communion and correlates with the dialectic of closeness and distance. 'Ways of knowing' encompasses a framework for gaining knowledge in different ways and presents two pathways, one emphasising connected knowing, the other emphasising separate knowing. Each journeys towards a constructed knowing position. My explanations of this multi-level schema relate to my exploration of nursing and the lives of nurses, and to my own life as a nurse in particular.



The Dialectics of Nursing - Expressions of Knowing and Being

The Dialectics of Nursing

From Submerging to Surfacing is a movement that involves dialogue, sometimes within oneself and sometimes with another. This dialogue is at times open, at times blocked, and at times at peace. Dialogue is always held within and influenced by a given context. This being so, the ability to speak freely and dialogue effectively will also influence the quality of any dialogue. From Distance to Closeness is a different kind of communication, one of aliveness to others and attentiveness to another's needs. The transaction between is not as easy to understand, it is intuitive and inward-outward sensing.

The four spaces contained within the framework represent movement between these two central strands. Each of the opposing spaces contains polar opposites in muted or overt form, and each space has its range of possibilities. For instance, in moving from Closeness to Surfacing, one encounters Power and Voice. This is the power to own knowledge, to be oneself and to be valued for the reciprocity within any relationship. Voice is about confidence, a 'straightness' of speech and a clarity of personal self. The space between Surfacing and Distance holds Curing and Safety, and is about the certainty of goals and tasks and the need to know before taking action. It is the dialogue of facts and clear agendas. This space holds a sense of certainty even when the goal is to 'find out'.

The space between Closeness and Submerging holds Powerlessness and Silencing. This is the experience of being alienated, suppressed and devalued, and it is here one can be thrust when power is felt as coercive and aggressive. The final space between Submerging and Closeness is Caring and Vulnerability, a familiar place for me, and one that holds a silence and a sense of worth that relates intimately to a sharing of self. It is at once affirming and at risk. I am able to place myself within this space because in most situations I have choice. This is not the case for nurses who are unable to make other choices for fear of failure, rejection or punishment. Sometimes I choose and feel the pain of being vulnerable, and occasionally I question my own choosing.

Having provided a short explanation of the themes suspended in this schema, I will now turn to the connections I have explored between ways of knowing, gendered life strategies and the nature of nursing. The diagram 'Dialectics in Nursing - Expressions of Knowing and Being', is a representation of these connections and provides a visual map of the territory I will now attempt to describe. I will begin by explaining how 'Ways of Knowing' can be seen both as developmental pathways and also as choices that relate to gendered lifestyles.

Ways of knowing and gendered lifestyles

Belenky et al (1986) consider whether the way women learn is a developmental process that begins with the experience of silence (having no voice), and journeys through received knowing, subjective knowing, procedural knowing, and eventually arrives at constructed knowing. I am not sure precisely what is meant by development in relationship to ways of

knowing. However, having reflected on my own life path and listened to the stories of other women, I now have a sense of a developmental process that is context bound. From my perspective, this means that each person may learn to: speak from silence; understand and 'speak from' the knowledge of the other; explore and create a personal and 'subjective' sense of reality; co-create reality through connecting and understanding the world of others, or through debating contrasting and analysing (both are 'procedural' knowing).

It is also possible that some people reach a point in their journey where:

> "To see that all knowledge is a construction and that truth is a matter of the context in which it is embedded is to greatly expand the possibilities of how to think about anything, even those things we consider to be the most elementary and obvious. Theories become not truth but models for approximating experience; as one woman said "not fact but educated guesswork'." (Belenky et al, 1986, p.138)

Travelling into these different territories of awareness and interaction with the world may be developmental. However it also dependent on factors within a person's life that create a climate for change.

As I reflect on my own discoveries about myself and the world, I can locate particular experiences that seemed to release me to think differently. Or was it that I had permission to express the thoughts and understandings I was nurturing? Is it also the case that the thoughts I was nurturing emerged from my ability to think differently, or an event in my life that gave me that impetus for change? The reasoning is circular, therefore to avoid the risk of becoming paralysed, I have taken the stance that different ways of knowing are contained within a developmental process. This has allowed me to consider the relationship between these possible developmental pathways and the schema (Dialectics of Nursing), and to map two pathways from 'silence' to 'constructed knowing'. However, in doing this, I have discovered that mapping ways of knowing required a clarity about the aspects of gender and ways of knowing and acting in the world that speak to gendered life strategies.

Considering the relationship between the nature of nursing, ways of knowing, and gendered life styles, led me to view the pattern emerging as embedded in an understanding of 'chosen' ways of interacting in the world. This is essentially about preferred life strategies, although I acknowledge that preference is about opportunity and choice is context bound. Given all this possible complexity about how each of us comes to know, makes choices, and seeks to construct an environment compatible with our life strategies, it seems to me that each person's preferred way of presenting 'self' to the world co-creates the nature of dialogue and the degree of intimacy in relationships. This preferred way of engaging will then expose the genderedness of each person's life strategy.

With this in mind, I have mapped both ways of knowing and gender as if a choice of direction is made - towards the feminine or towards the masculine. If one chooses the feminine, then

communion will be the preferred strategy and one will travel from silence through received knowing, subjective knowing, and then to connected knowing. If one chooses the masculine then one moves towards agency and separate knowing. From my understanding of this journey, once these ways of knowing are experienced then there is a movement between according to the context one finds oneself in. Within this there is a freedom to hold all ways of knowing within consciousness and to bring each to bear as new constructions of reality emerge. Having given my voice to the way this research journey has entered my life, I will now consider the themes that emerged from the work we did together.

The themes that held significance

Before I consider the possibilities for the future and the way in which this research journey is influencing my practice now, I will reflect on the themes that held significance throughout the field work and created the pattern of interaction during the second research cycle. These themes are:

- Working effectively together and affirming teamwork
- Personal identity and role expectation
- Caring for and with others

'Working effectively together and affirming team work' surfaced in many of the stories and was present in different forms in the first research cycle. The research made clear to me that nurses need to work together in order to practice effectively. However, the way in which nurses express this need to have time to together to think, share concerns and inform each other, is rarely clearly articulated. Some times it is expressed through stories as we seek to reduce anxiety and dispel negative feelings, some times it is about dispelling self doubt, and sometimes it is about sharing 'good practice'. There are actions that nurses can take to increase the value of working together. Some of these actions will require a firm sense of what it means to be a nurse and to take authority over ones own role.

This brings me to the second theme that echoed through the research creating conflicts and difficult decisions. *'Personal Identity and role expectation'* are intertwined for nurses in such a way that confusion arises around the issues of responsibility and authority. Conflict between the role expectations of nurses and the expectations of others is a tension that nurses carry continuously. Finding a sense of integrity that manages these tensions is not easy, particularly as continuous change seems to be an integral part of organisations. As the roles of others change, so the pressure increases on nurses to extend their roles. However, despite all this pressure for change, there remains central to nursing the *'primacy of caring'.*

This centrality of caring was a theme that many of us struggled with because of the roles we had as nurse managers or nurse teachers. The struggle for some was coming to terms with being a nurse and not having direct involvement with patients. This anxiety seemed to fade and a clarity about the caring role emerged as the research journey progressed. There is, and

has not been for some time, a question in my mind about the relationship between the role of the nurse and the primacy of caring. Nursing is *caring for and with others* , and although the demands from managers and other professionals might press for a different emphasis, nurses gain their power and their voice within this role. I am hopeful that in my own stories I have demonstrated the way in which this centrality of caring can also enhance colleague relationships, particularly where trust and closeness is affirmed.

Before I leave these brief reflections it is important to note that these themes were also significant in developing the schema *'Dialectics within nursing'*. Further exploration of how this related to each theme and to the wider context of gendered roles and power relationships cannot be undertaken here. .

Reflections and Conclusions

I have reached the end of this particular journey with a sense of closure and some new beginnings. As I consider the tentative schema I presented in this chapter, I am aware that the development of it was very interactional. The final pulling together of the pieces occurred when David, my husband, was helping me through a very dense part of my experience of nursing. He started to list some of the words that kept recurring and this encouraged me to search my mind for the images that held meaning and felt familiar. It was here that I reconnected with the rhythms in the thesis. The mapping and testing of it came a little later. Although I have 'just arrived' at this schema as an explicit representation of what emerged from the research, I realise that this has been implicit in the ways I have been practising professionally. As I write this I recall two situations where I presented this schema to two of my male nursing colleagues (I had just developed the Dialectics of nursing at this point in time). I would like to take a moment and describe our interactions because it poses a question for me about the genderedness of nursing.

These two scenarios occurred within a day of each other. The first interaction is with Matthew who is a black African originally from Zimbabwe. He was not a member of my research group and has quite recently joined my nursing staff. He is a clinical nurse specialist with post-basic degree in family therapy and I have a mentorship role with him. We had been meeting regularly over the past nine months to discuss and debate the issues we face as nurses, and in particular Matthew's career path. We have a sense of 'knowing' each other because of my experiences working with the Maori people and Matthew's sense of harmony with feminist writers, particularly 'Women's Way of Knowing' (Belenky et al). Discussions about life strategies and making sense of troubled organisations has been a steady part of our dialogue together. It was at one such meeting that we discussed my thesis and I presented to him my tentative schema.

We went through the two main strands together and reflected on our own positions within it. Matthew then asked me to take him round the circle and tell him what I had in mind with

regard to movement . I did this, and then he said, "You know the potential for the 'other' is always there." I asked him to explain what he meant, He said, "I am really struggling with this question of power, and now I can see that it is there when one is powerless, and powerlessness is there when power is operating." Then he added, "This is more hopeful, so how do you move people from this position of powerlessness and silencing to power and voice?"

Then I saw the real potential of this schema and I described how the two strands were the links that provided a pathway to each space. From this point we discussed how it was important to first find a way of empowering nurses to begin the process of surfacing what is being submerged. Then, when this has begun, to start the process of creating closer relationship with significant others in their work situations. The intention, we agreed, was to help inexperienced nurses to take authority over their lives and work. We parted on a 'high note'.

The next day I met with Gerrard who is a nurse teacher and was a member of the research group. He came in to see me on his way to one of the acute wards where he has been 'team building' with the nurses. He was telling me that because of the recruitment crisis, and the unplanned changes, he was finding it difficult to get any 'energy flowing'. I asked him if he had read the last part of my thesis and he replied "I have just about finished it, I have not read your stories yet." I then asked if he would like to see what I had made of it all and I showed him the schema. Our interaction was almost a repeat of the one the previous day with Matthew, except that we took the discussion a little further and looked at the practicalities of working with the group of nurses he was about to meet. It went something like this:

"OK, where are they on the schema?"

"They are at the bottom right hand corner, powerless and silenced."

"Well, first you need to get some dialogue going and bring them towards surfacing what they want to say. Then, when you get them moving a little, find out who they see themselves as distant-from and need to be closer-to. Then consider the ways in which they might engage with these persons in a way that brings them a sense of being valued and included. The aim is that they locate their power and find a voice to express their own ways of knowing."

Gerald said "Thanks,"' and rushed out to keep his appointment while I returned to my previous task.

My agenda for the future.

In considering the way forward, I have three agendas. The first is about the context in which nursing is practised, and the question is raised about how much we as nurses are able to influence this. The second is an energy to explore further the schema that I have tentatively proposed, and to consider what implications this might have for developing ways of working that will give nurses some control over their lives. The third is to consider how I can support

nurses in meeting together and managing their roles in a way that affirms their practice and helps them 'sit comfortably' with their peers and colleagues. Finally, for myself I will continue to explore my own ways of knowing and develop ways of encouraging nurses to explore their thinking within a supportive and challenging environment.

Epilogue

My aim now is to introduce the voices of nurses who have read and commented on this thesis. I will begin with the voices of fellow researchers and end with the nurses who are presently part of my working life. I requested my 'fellow travellers' to give me feedback from their point of view as participants and colleagues. They were given the research texts that explored the two cycles of research. A few requested the complete thesis and made their comments based on this. To the colleagues I work with, I offered the first draft of my thesis in sections and requested their feedback. This feedback added to my understandings of this journey. In giving feedback, some people wrote a letter while others came and discussed some of the issues with me. The dialogue I now present has been either transcribed, edited, or reconstructed.

The voices of fellow travellers

"I am a witness to the work we did together and your thesis confirms the process I experienced, it is true to the experiences I had. I can recall the group process and your sense of self that you expressed. It was important for me to listen to others' narratives, and make sense of it within my own life. It was a very validating experience - knowing that my own experience mirrors the experiences of others. "

"it surprised me. It is not like an academic exercise, it is as if you are talking to me, and I can hear our voices in it. It is your journey and ours, the group work was very important, it was not a support group or a therapy group. The honesty you held could be missed by people who were not there. Most of all it is transferable into my work situation, I remember snippets and reflect on them. I have taken it into other parts of my life as well."

"It was a unique experience to take time out and reflect on myself as a person and as a nurse- a 'rich experience'. Having my own insecurities and understandings accepted by other group members. It was a learning opportunity that I have used outside of that setting."

"I am afraid I have to be honest, when I got your thesis I went straight to the group work and found it fascinating. It was just like being there again, I could remember it all and I learned so much from reading what you made of it, and your own life stories. I remember again my experience of telling my story and what a relief when I eventually got it out."

I do not think I need to comment except to say that the group we developed to do this research was not a work group, it was something different. There is a question here I need to ponder on because this kind of group is an 'extra', not a part of the everyday working life. It is a way of working that could develop a 'community of inquiry', but the culture of co-operation is difficult to achieve in the organisational climate in today's NHS.

The voices of the nurses I work with

"It certainly makes me think differently about nursing, particularly the role of women, using yourself and experiences to explain the issues. I feel it overlaps well with the field work. It left me wondering, however, about what place there is for men's thoughts and feelings as nurses? I have certainly been able to create (for myself) a new way of explaining the essence of nursing. It is a very well thought out thesis and is thought provoking."

"The part that I enjoyed most was the way you drew meaning out of the dialogue, and the way you discussed it and took it forward. I have not read it all yet but I will give you feed back when I have."

"The effect on me of reading this thesis has been considerable. Inevitably different stories have 'spoken' to different parts of me. I found myself revisiting and rewriting some of my own stories. Although the temptation to punctuate the author's stories has been immense, I dealt with this by reminding myself that what ever meaning I read into the author's, this says more about me than the author. I have therefore been able to use the stories reflexively. During the process I have experienced a range of emotional, behavioural, and cognitive reactions including anger, comfort, validation, soothing, challenge, confirmation and empowerment. The issues around power, control and identity were repeatedly highlighted by different stories. I have been left grappling with how, without sharing a vision (demonstrated by Neil), ordinary nurses can begin to address power issues (as demonstrated by Andrew and William). How does one avoid stories becoming self pitying traps and pipe-dreams for the powerless, with the powerful paying lip service to the desirability of empowering the weak, whilst consolidating the power around them?"

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